SafER Space

A Human-Centred Experience for Advancing Child & Youth Mental Health in Emergency Departments

MYLES AHEAD
ADVANCING CHILD & YOUTH MENTAL HEALTH

Truth & Land Acknowledgement

Myles Ahead, Advancing Child & Youth Mental Health ("Myles Ahead") was established to create system changes that will help children, youth, and their families access timely and appropriate mental health supports, with the ultimate objective of life promotion (i.e., suicide prevention). Myles Ahead is a national charity, operating in Tkaronto, Ontario, Turtle Island, and we wish to acknowledge that we are on the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee, and the Wendat Peoples. Tkaronto is now also home to many diverse First Nations, Inuit, and Métis Peoples.

Myles Ahead also acknowledges that Tkaronto is covered by Treaty 13 signed with the Mississaugas of the Credit, and the Williams Treaties signed with multiple Mississaugas and Chippewa bands.[1] Given our focus on life promotion for children and youth, we particularly want to acknowledge that the suicide rates of Indigenous youth in Canada are alarmingly and heartbreakingly high.

Suicide is the second leading cause of death among children and youth aged 10 to 29 in Canada.[2] For First Nations people, the rate of suicide climbs to 6.2 times higher than the rate for non-Indigenous Peoples in the same age range.[3] For Inuit people, the rate of suicide skyrockets to 23.9 times higher.[4]

Canada's racialized systems of inequity have existed since confederation and this reality was amplified by the Indian Act (1876), which is still in effect today. The Indian Act "has enabled trauma, human rights violations and social and cultural disruption for generations of Indigenous Peoples."[5] Although mandated Indian Residential Schools and Indian Day Schools are now closed, as of 1996[6] and 2000,[7] respectively, their traumatic effects are ongoing for First Nations, Inuit, and Métis Peoples.

In addition, while most of the racially segregated Indian Day Hospitals are now closed (two remain in operation by the federal government), given they were "intended to further assimilationist goals," their traumatic effects are also ongoing for First Nations,

1 Ontario Government. "Map of Ontario Treaties and Reserves.", *Government of Ontario,* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3381767/

2 Skinner, Robin, and Steven McFaull. "Suicide among children and adolescents in Canada: trends and sex differences, 1980–2008." CMAJ 184.9 (2012): 1029-1034. https://dx.doi.org/10.1503%2Fcmaj.111867

3 Macdougall, Greg. "Canada's Indigenous Suicide Crisis is Worse Than we Thought.", *Canada's National Observer,* 10 Sep. 2019, https://www.nationalobserver.com/2019/09/10/analysis/canadas-indigenous-suicide-crisis-worse-we-thought#:~:text=The%20highest%20rates%20of%20Indigenous,rate%20is%2023.9%20times%20higher

4 Ilbid

5 Parrott, Zach. "Indian Act.", *The Canadian Encyclopedia,* 7 Feb. 2006, https://www.thecanadianencyclopedia.ca/en/article/indian-act#:~:text=First%20introduced%20in%201876%2C%20the,the%20removal%20of%20discriminatory%20sections

6 Marshall, Tabitha, and David Gallant. "Residential Schools in Canada.", *The Canadian Encyclopedia,* 10 Oct. 2012, https://www.thecanadianencyclopedia.ca/en/article/residential-schools

7 Federal Indian Day Schools. "Schedule K – List of Federal Indian Day Schools.", Federal Indian Day Schools, https://indiandayschools.com/en/wp-content/uploads/schedule-k.pdf

Inuit, and Métis Peoples.[8] The oppressive seeds of confederation were planted almost 155 years ago and continue to mutate in various forms, such as the overrepresentation of Indigenous Peoples in Canada's prisons (Indigenous youth comprise 7% of all youth in Canada, although Indigenous girls represent 44% of female youth and Indigenous males represent 29% of male youth in prisons[9]) and the child welfare system (Indigenous children represent 52.2% in foster care, although they represent only 7.7% of the child population[10]); Missing and Murdered Indigenous Women, Girls, Two Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, and Asexual (2SLGBTQQIA+) People (Indigenous females represent 16% of all female homicide victims, and 11% of missing females, despite Indigenous people representing 4.3% of the population in Canada[11]); and, as of November 1, 2021, 99 drinking water advisories persist within Indigenous communities.[12]

As the Government of Canada continues to uphold colonial policies and practices that oppress First Nations, Inuit, and Métis Peoples, including deprivation of their rights to self-determination and sovereignty, this continues to have varying negative impacts on their multidimensional wellness. Myles Ahead is grateful for the stewardship and contributions that Indigenous Peoples have in protecting and honouring Turtle Island.

We are dedicated to aligning our efforts to the advancement of the United Nations Declaration on the Rights of Indigenous Peoples, the Truth and Reconciliation Commission of Canada's 94 Calls to Action, and the 2021 Missing and Murdered Indigenous Women, Girls, and 2SLGBTQQIA+ People National Action Plan: Ending Violence Against Indigenous Women, Girls, and 2SLGBTQQIA+ People.

We also honour the cultures and teachings of Indigenous Peoples. We are indebted to their ways of knowing, being, and doing that strengthen the children and youth connection with Elders, communities, cultures, and lands, which are also life-promoting and protective factors for All.

---

8 Ontario Human Rights Commission. "Interrupted Childhoods: Over-Representation of Indigenous and Black Children in Ontario Child Welfare.", *Ontario Human Rights Commission,* https://www.ohrc.on.ca/en/interrupted-childhoods#4.1.Indigenous%20children

9 Government of Canada; Indigenous Services Canada. "Reducing the Number of Indigenous Children in Care.", *Government of Canada; Indigenous Services Canada,* 17 Jan. 2022, https://sac-isc.gc.ca/eng/1541187352297/1541187392851

10 Government of Canada; Department of Justice. "Statistical Overview on the Overrepresentation of Indigenous Persons in the Canadian Correctional System and Legislative Reforms to Address the Problem.", Government of Canada; Department of Justice, 12 Apr. 2019, https://www.justice.gc.ca/eng/rp-pr/jr/gladue/p2.html

11 Assembly of First Nations. "Missing and Murdered Indigenous Women and Girls and Ending Violence.", *Assembly of First Nations,* https://www.afn.ca/policy-sectors/mmiwg-end-violence/

12 Luo, Carina Xue. "The Water Crisis in Canada's First Nations Communities.", *University of Windsor,* Academic Data Centre, 14 Nov. 2021, https://storymaps.arcgis.com/stories/52a5610cca604175b8fb35bccf165f96

Anti-Violence Policy

Myles Ahead, Advancing Child & Youth Mental Health ("Myles Ahead"), acknowledges that violence is pervasive within our society. Violence directed towards racialized and marginalized people within Canada requires dedicated action to advance awareness and constructive approaches to help create a just and safe culture for everyone.

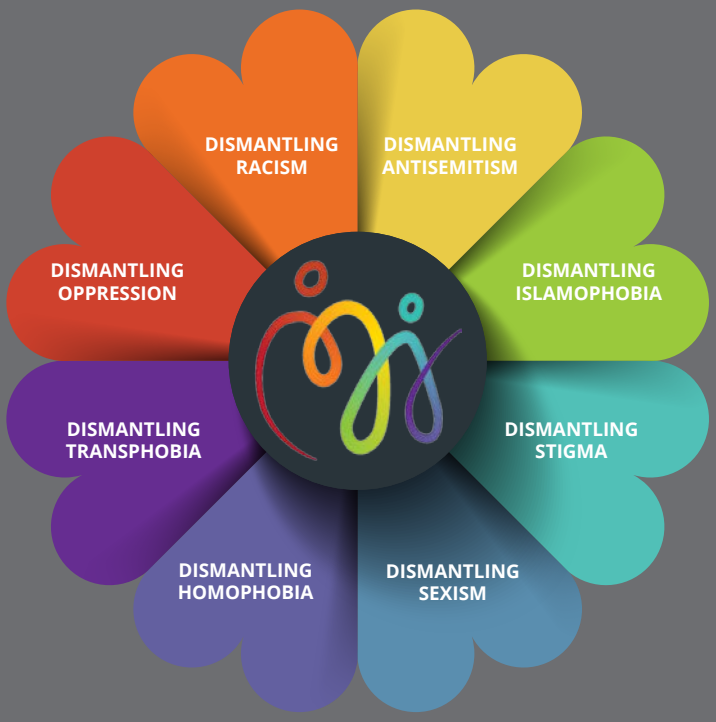
For this policy, violence is defined to include, yet not limited to, any form of racism, stigmatization, discrimination, marginalization, sexism, heterosexism, homophobia, and transphobia, among any belief, bias, behaviour, practice, policy, and/or system that oppresses. As documented in this policy, Myles Ahead is dedicated to creating an organizational culture that is safe for everyone: inclusive, decolonized, diverse, equitable, accessible, and anti-violent (IDEA).

It is fundamental that Myles Ahead's practices and products reflect this policy to fulfil our mission to advance child and youth mental health in Canada. Racism is deeply entrenched and widespread in society; particularly, for more than a century, anti-Indigenous racism and anti-Black racism is a chronic form of violence. Violence towards First Nations, Inuit, Métis, Black People, and other Powerful Groups Targeted for Oppression, has devastating impacts that cause lifelong and intergenerational trauma.

For example, some of these impacts include the cause and/or exacerbation of mental health challenges and barriers to accessing timely and suitable mental health supports. Tragically, First Nations, Inuit, Métis, and Black People are especially underserved by mental health support systems and over-represented in the child welfare and youth justice systems. Without equitable access to child and youth mental health services, these communities experience poorer mental health outcomes than other communities.

One way that Myles Ahead demonstrates our dedication to anti-violence is by embedding IDEA practices as a fundamental principle to co-design our initiatives. In addition, our dedication to anti-violence, as illustrated in the diagram below, yet not limited to, is also demonstrated by the following actions:

- *Providing foundational and ongoing IDEA training for employees and Board members;*
- *Initiatives, policies, and practices are aligned with this policy, including best practices related to anti-violence; and,*
- *In recognition that language has an immense impact on creating a trusting, respectful, and non-judgmental culture, and that language is constantly evolving, Myles Ahead regularly (at a minimum, annually) reviews and adjusts language in our documents and on our website, among other media, to reflect IDEA best practices.*



Myles Ahead pledges to be an active partner, supporter, and ally in co-creating a safe and just world for everyone, as outlined in this policy. We stand firmly with our partners to eradicate all forms of violence.

Contributors

On behalf of Myles Ahead, Advancing Child & Youth Mental Health, with oversight and guidance from its Mental Health Services Sub-Committee, in addition to an advisor, “SafER Space, A Human-Centred Experience for Advancing Child & Youth Mental Health in Emergency Departments” was co-created by the following contributors:

Authors
Leslie Kulperger, Founder & Executive Director
Myles Ahead, Advancing Child & Youth Mental Health

Nicole M. Weatherly, Director of Transformation
Myles Ahead, Advancing Child & Youth Mental Health

Researcher
Chloé Simms, Research & Development Analyst
Myles Ahead, Advancing Child & Youth Mental Health

Authors’ Note

SafER Space is an initiative made possible by Myles Ahead’s dedicated team, community partners, and generous donors.
For inquiries concerning SafER Space and this publication, contact Leslie Kulperger at lkulperger@mylesahead.ca.

Contents

Executive Summary

Canada has one of the highest child and youth suicide mortality rates among all countries that are members of the Organisation for Economic Co-operation and Development (OECD),[1] indicating children and youth in Canada are vulnerable to mental health distress. Despite this vulnerability, publicly available mental health services for children and youth are chronically underfunded and oversubscribed, leading to lengthy wait times.

In the absence of early intervention supports, emergency departments (EDs) frequently appear to be the only option available to help children and youth when they are experiencing mental health challenges. Unfortunately, EDs have not been designed, equipped, or resourced to attend to the growing mental health needs of the communities that they serve.

There is an opportunity to improve the experiences of children, youth, and their caregivers/families while seeking ED care. These opportunities include small changes that can have a significant impact, such as introducing design features to reduce noise and foot-traffic to promote greater stability and regulation for people in mental health distress.[2] Although children and youth arrive at the ED in need of immediate mental health support, they are often left waiting many hours. Mental health clinicians are typically not integrated in EDs, which directly impacts the wait time and can lead to heightened levels of anxiety and greater potential for Code Whites. For children and youth, a Code White experience is extremely traumatizing. Adding to the mental health impact that EDs can have, once stabilized, patients are often discharged without any follow-up support plan. A negative ED experience can compound pre-existing mental health challenges, resulting in numerous negative outcomes for the patient, including fear and anxiety associated with EDs, greater risk of escalation with repeat visits to EDs, and potential suicide.

Exacerbating this reality, the pandemic has created a dramatic increase in the need for mental health supports for the vulnerable and young. For example:

- youth suicide-attempt hospital rates increased three-fold in a four-month period during the 2020-2021 winter lockdown;[3] and,
- unprecedented eating disorders in youth; instances of newly diagnosed anorexia nervosa or atypical anorexia nervosa increased by more than 50% with hospitalization rates over 2.5 times greater during the first wave.[4]

1 "International Suicide Rates of Youth 15 to 24 Years of Age, Canada and Other OECD Countries – the Health of Canada's Children and Youth." *The Health of Canada's Children and Youth, A CICH Profile*, (2012), https://cichprofile.ca/module/1/section/5/page/international-suicide-rates-of-youth-15-to-24-years-of-age-canada-and-other-oecd-countries/.

2 Kendal, Sandi. "From "Emergency Couch" to Emergency Care: Providing Health Care Options to People in Mental Health Crisis." *Network* 25.2 (2009): 9-13. https://ontario.cmha.ca/wp-content/files/2013/04/fall_2009.pdf

3 Children's Healthcare Canada. "Expanding Urgent Health Supports for Canada's Children And Youth", *Children's Health Canada*, 19 April 2021, static1.squarespace.com/static/5bd8a55e4eddecb150a2acdb/t/607f615f39c5cd3dffa401b1/1618960736458/Expanding+urgent+health+supports+for+Canada.pdf

4 Agostino, Holly, et al. "Trends in the Incidence of New-Onset Anorexia Nervosa and Atypical Anorexia Nervosa Among Youth

The compounded effects are even more evident in consideration of the disproportionate multi-generational trauma and mental health challenges of underrepresented and underserved communities. The risk of suicide for Indigenous youth is over five times the risk of suicide for non-Indigenous youth,[5] while the suicide rates for Inuit people are among the highest in the world, estimated up to 25 times higher than the national average.[6]

THIS IS AN EMERGENCY
THE TIME FOR ACTION IS NOW

The pandemic has exposed the dire need to change Canada's approach to mental health supports, and the cost of inaction extends beyond the human experience. When combined, health care, lost-time productivity, and reduced quality of life are estimated to cost the Canadian economy $51 billion annually.[7] This does not include the $950 million that approximately 30% of Canadians pay to access services privately.[8]

In consideration of the growing number of people who are seeking mental health support from EDs while in heightened states of vulnerability (especially children and youth), the high instances of workplace violence in EDs, and the absence of alternative emergency services for people in acute mental health distress, the time to reimagine EDs is long overdue.

In response to the mental health emergency, SafER Space is a human-centred experience for advancing child and youth mental health in EDs. It reimagines EDs to better support children and youth who are experiencing a mental health crisis.

SafER Space

SafER Space consists of a scalable framework and a transformation toolkit for implementation and sustainment, providing hospitals with a roadmap to co-design every aspect of reimagining EDs toward best practices. The framework includes three-phased considerations, starting with low-cost and easily-implementable solutions (i.e., Phase 1) that advance toward Phase 3, which fully reimagines EDs.

As an emerging concept, the body of evidence to support the redesign efforts of EDs for mental health is relatively new but extremely promising. Given the ED is frequently the first point of access to mental health services for Canadians,[9] it seems fitting that the ED is the first to transform and become a SafER Space.

During the COVID-19 Pandemic in Canada." *JAMA Network Open* 4.12 (2021): e2137395-e2137395. https://doi.org/10.1001/jamanetworkopen.2021.37395

5 Government of Canada; Indigenous Services Canada. "Suicide Prevention in Indigenous Communities." *Government of Canada; Indigenous Services Canada*, 17 Jan. 2022, https://www.sac-isc.gc.ca/eng/1576089685593/1576089741803#sec1.

6 Affleck, William, et al. "Suicide Amongst the Inuit of Nunavut: An Exploration of Life Trajectories." *International Journal of Environmental Research and Public Health* 17.6 (2020): 1812. https://doi.org/10.3390/ijerph17061812

7 Moroz, Nicholas, Isabella Moroz, and Monika Slovinec D'Angelo. "Mental Health Services in Canada: Barriers and Cost-Effective Solutions to Increase Access." *Healthcare Management Forum* 33.6 (2020): 282-287. https://doi.org/10.1177/0840470420933911

8 Ibid

9 Butler, A., et al. "Towards Quality Mental Health Services in Canada: A Comparison of Performance Indicators Across 5 Provinces." *Vancouver BC: Centre for Applied Research in Mental Health & Addiction (CARMHA)*, (2017): 1–134. http://www.sfu.ca/carmha/publications/prov_indic_2017.html.

1.0 Background

The SafER Space framework and transformation toolkit for implementation and sustainment is **driven by a management system review of the Canadian mental health landscape and informed by the continuum of risk.** The most severe consequence within the risk continuum is a mental health related fatality. Given the child and youth suicide rates in Canada have been among the highest of all OECD countries for decades, there is a clear need to investigate and improve the systems supporting children and youth who are experiencing suicidality.[10]

> ***"Myles was suicidal before we arrived in the ED, and after the traumatic experience we had there, I was worried the risk would be even greater. Unlike our previous visits to the ED, I refused to be discharged without a plan."***
>
> ***– Leslie Kulperger, Myles' Mother***

Some may debate that EDs are not the right place to provide support for people who are experiencing a mental health challenge, since that was not their original purpose. Historically, EDs have not been designed, equipped, or resourced to serve the growing mental health needs of the communities that they serve. In this sense, the growing mental health needs are "disrupting" the original purpose of EDs. In the absence of readily available alternative urgent support facilities, EDs will continue to be the obvious place for people to turn to while experiencing a mental health crisis. The thing about disruption is that it often provides the catalyst for change. If EDs are to continue to serve urgent community mental health needs, then the disruption caused by the increasing need for mental health support presents an obvious opportunity to reimagine the EDs so that they can be there for people in times of mental health crisis.

Reimagining EDs to better serve people's mental health needs is an emerging practice that has demonstrated incredible potential. For example, the use of physical restraints, often a mitigation effort to avoid physical violence by a patient toward hospital employees or themselves, were reduced by 50% in a psychiatry ward in Sweden,[11] and reduced to less than 1% in hospitals with EmPATH (Emergency Psychiatric Assessment, Treatment, and Healing) units in the USA.[12] EmPATH units also see a significant reduction in mental health related hospital admissions.

For the purpose of developing the SafER Space framework and transformation toolkit for implementation and sustainment, Myles Ahead conducted **an environmental scan of current ED practices** in pediatric and the largest general hospitals across Canada. **Four Canadian experts and three international experts were interviewed.** Myles Ahead also conducted a **best practice literature review** (Section 3.0), which revealed strong evidence to support how the recommended SafER Space changes to resourcing, processes, and physical design of EDs can significantly improve patient stabilization and overall mental health.

10 McLoughlin, Aoibheann B., Madelyn S. Gould, and Kevin M. Malone. "Global Trends in Teenage Suicide: 2003–2014." *QJM: An International Journal of Medicine* 108.10 (2015): 765-780. https://doi.org/10.1093/qjmed/hcv026

11 Ulrich, Roger S., et al. "Psychiatric Ward Design Can Reduce Aggressive Behavior." *Journal of Environmental Psychology* 57 (2018): 53-66. https://doi.org/10.1016/j.jenvp.2018.05.002

12 Zeller, Scott. "EmPATH Units as a Solution for ED Psychiatric Patient Boarding." *Psychiatry Advisor*, 2018, www.psychiatryadvisor.com/home/practice-management/empath-units-as-a-solution-for-ed-psychiatric-patient-boarding/.

While the literature revealed strong evidence that the rationale for the SafER Space framework is sound, the expert interviewees who experienced implementing changes within hospitals, cautioned that the resistance to change was a particularly difficult barrier to their projects. Resistance to change is not surprising; approximately **30% of all change initiatives fail.**[13] In the change management world, change resistance is expected and planned for, which is why **it is critical to have a structured change management approach,** in addition to project management. Although change management is not a new concept, it is not yet a universally understood or appreciated process. Thus, the SafER Space framework includes a comprehensive transformation toolkit with templates, used by leading-edge change management practitioners to successfully implement and sustain organizational change.

In addition to the environmental scan, best practice literature review, and interviews with subject matter experts, Myles Ahead also considered why SafER Space would present a desirable option for hospitals. To support this, Myles Ahead **reviewed 10 hospital scorecards and key performance indicators (KPIs) that have a high probability of relating to patient mental health escalations,** such as: workplace violence, lost time work, and employee workplace insurance claims, to name a few. Included in this review, Myles Ahead examined associated quality improvement plans (QIPs) for KPIs that were under-performing. The QIPs demonstrated a consistent priority focus on reducing incidents of workplace violence. Workplace violence appears consistently to be a significant concern for ED employees and has a more than 30% correlation with patients who are experiencing severe mental health distress.[14]

> ***"I had very little care for a lot of difficult symptoms (only a few walk-in clinic visits) until I was in crisis. My family took me to the ER, where I waited for many hours to see someone. After that wait I saw the ER doctor, but not a mental health professional. I was discharged in the early morning with no follow-up of any kind. My parents were told that I was just behaving badly. I later learned that there was a mental health team working at that ER, but was not referred to them. I had two more similar experiences in the ER over a couple of years, before I was referred to the appropriate type of care."*** [15]
>
> ***– Anonymous***

The QIPs also indicated that early screening for mental health escalation risks and Code White de-escalation training have been prioritized to decrease workplace violence. When we consider the wait times for early intervention mental health supports can be as long as 2.5 years in some regions, with urgent intensive treatments taking over three months to access,[16] EDs may appear to be the only option to get much-needed mental health support. Since EDs were not designed or resourced to support mental health challenges

13 Sirkin, Harold L., Perry Keenan, and Alan Jackson. "The Hard Side of Change Management." *The Harvard Business Review*, October 2005, https://hbr.org/2005/10/the-hard-side-of-change-management

14 Sibbald, Barbara (2017) Workplace Violence is not part of a doctor's job. Canadian Medical Association Journal February 6, 2017 issue https://www.cmaj.ca/content/189/5/E184

15 Butler, Amanda & Adair, Carol & Jones, Wayne & Kurdyak, Paul & Vigod, Simone & Smith, Mark & Bolton, James. "Toward Quality Mental Health Services in Canada: A Comparison of Performance Indicators across 5 Provinces." CARMHA - Centre for Applied Research in Mental Health & Addiction, August 2017, https://www.sfu.ca/carmha/publications/prov_indic_2017.html

16 Moroz, Nicholas, Isabella Moroz, and Monika Slovinec D'Angelo. "Mental Health Services in Canada: Barriers and Cost-Effective Solutions to Increase Access." *Healthcare Management Forum* 33.6 (2020): 282-287. https://doi.org/10.1177/0840470420933911

and are often noisy, busy, and highly stimulating environments, they can have an adverse effect for people who are experiencing mental health distress. While training employees to identify and de-escalate Code White situations, this approach does not address the underlying ecology of the ED. Considering the alarming children and youth suicide statistics, the long wait times to access mental health supports, the hospital workplace challenges with violence, and the increasing mental health needs of children and youth, **the need to address the role EDs play in the mental health continuum is undeniable.**

The rationale for creating the SafER Space framework and transformation toolkit for implementation and sustainment also stems from personal lived experience. Myles Kulperger's 2018 suicide death at age 11 was the catalyst for founding Myles Ahead, Advancing Child & Youth Mental Health. Myles' traumatic ED experiences may have been avoided if the ED felt safe and was resourced to receive children and youth in mental health distress.

In the brilliant words of Maya Angelou, "If one is lucky, a solitary fantasy can totally transform one million realities." **Imagine how many realities will be changed when every ED becomes a SafER Space.**

1.1 Case Study

Emergency Departments were Traumatic for My Son's Mental Health

Background

At six years old, a few months after our dog died, my son was struggling to stay regulated at school. Self-regulation had been a challenge for Myles in the past in certain settings, but it became clear that we needed professional help. The school administrator recommended a psycho-educational assessment to help determine what Myles' needs were, although she noted the waitlist was over one year for the school board's psychologist. Feeling one year was too long to wait, and in the absence of any guidance from the administrator, I began searching in earnest to find someone to conduct the assessment.

After researching and contacting local child psychologists without success for a variety of reasons (e.g., the information I found online was out of date, private psychologists were not taking new patients / had moved their practice, the waitlist for the assessment was six months long), I sought the guidance of our family doctor. My doctor did not have any resources or information beyond what I could find online, though she thought I could likely get expedited access to services at the local hospital psychiatry team if I brought Myles to the ED. I continued my search, reaching out to family members and friends trying to find a word-of-mouth recommendation, continuing to call various public agencies, such as Hincks Dellcrest and Aisling Discoveries, all the while watching my son struggle. Out of desperation, I finally brought my son to the ED in June 2012.

Recalling this painful experience is difficult. I recognize that if Myles was alive today, I would not be able to share this story out of respect for his privacy. Myles is no longer alive, and his privacy is moot. If there is any chance that our experience can help change things for the better, I feel compelled to hold back my tears and share.

What happened at the Emergency Departments?

When we arrived at the ED, I explained that we needed help for my son who was having challenges staying regulated at school. We were told to wait in the waiting room. The triage nurse was curt, the waiting room was uncomfortable and busy, filled with strange sounds and smells for a six-year-old. I tried to entertain Myles while we waited. He wanted to leave. As more time passed, growing bored with I Spy, tic-tac-toe, and other made-up games, Myles became more and more agitated. We watched as EMS arrived with patients on gurneys while my son's agitation mounted. I could see Myles was becoming de-regulated and the potential for escalation was imminent. I sought the advice of the ED triage nurse and explained my concerns. She appeared totally unsympathetic to my concerns. I get it; she is probably overworked, underpaid, and hears story after story of why so-and-so needs immediate attention. I asked if she had any idea how much longer we would have to wait. She said she would look into the status and told me to sit back down in the waiting room. I was about to take Myles home when we were called through to a curtained ED patient consult "room."

In the patient consult room, Myles' agitation escalated. He was scared and wanted to leave. I tried to calm him down. He was crying and thrashing out. What happened next was a blur: hospital security personnel came into the curtained room and placed **restraints on my six-year-old son's arms and legs, tethering him to the bed** while he cried out to me. I was in shock. I tried to soothe Myles. Eventually he was sedated.

The time passage while we were in the ED was a blur to me. I know we arrived at the hospital around 4pm and returned home an hour or so after Myles' 8pm bedtime. I don't recall how long we were in the waiting room, or how long he was sedated before the on-call psychiatrist eventually came to speak with me. I described our challenges and why I had come to the ED. **I was told I should not have brought Myles to the ED,** and that bringing him there likely traumatized him. I explained that my doctor had recommended that I come, that I didn't know where else to go – surely there was someone, somewhere who could help us. I felt lost, ashamed, and frustrated. I was able to pay for support, I was a skilled researcher, yet I could not find someone to do a psycho-educational assessment for Myles. After I explained the lengths I had gone through before arriving at the ED, **Myles' case was expedited with the hospital's psychiatry department** for Myles to be assessed.

Unfortunately, **the psychiatrist assigned to assess Myles was not a good fit** and was unable to assess him. I finally found a private child psychologist a few weeks after it was clear the hospital's psychiatrist was getting nowhere. The child psychologist was a good fit for Myles and was able to assess him in three sessions.

I wish I could say that was our last experience with the ED, but there were two others at a large pediatric hospital:

- When Myles was 9, I received a call from his school. He told his teacher he was going to kill himself. I immediately picked him up from school and he reiterated that he wanted to kill himself and told me he was hearing voices.
- At the time, Myles' psychologist was away on maternity leave, and **I had not been able to find another therapist to support him** despite my best efforts (he was on two waitlists). I was alarmed and thought he likely needed medication. I took him to a pediatric hospital ED hoping they would be able to help us.
- When Myles was 10, he was grieving the death of a beloved pet and began self-harming and doing impulsive, dangerous, things. He again told me he wished he was dead. I was worried he was going to seriously injure or kill himself.

I could not leave him alone. The situation continued to escalate for two weeks. Myles was unable to sleep. I tried everything I could think of to help him get relaxed enough to fall sleep, yet each night after hours of book-reading, beach-walking, and car-rides, when he thought he would be able to finally fall asleep, he would jump out of bed and spin out of control and begin hurting himself. I held him and tried to encourage him to cry, explaining that hurting himself physically wouldn't take away the pain he was feeling. He said it did. I finally took him to the pediatric ED again out of desperation.

Despite my efforts to keep Myles calm and my pleads with security personnel to let me calm him down, Myles was restrained and sedated both of these times at the ED too. When the on-call psychiatrist was going to send us home with a recommendation for medication and the suggestion to use Benadryl to help Myles sleep when Myles was 10, I was shocked. Myles was suicidal before we arrived in the ED, and after the traumatic experience we had there, I was worried the risk would be even greater. Unlike our previous visits to the ED, I refused to be discharged without a plan.

In retrospect, I guess I could have left my job and taken care of him fulltime. In retrospect, I could have done a lot of things differently. In retrospect, the hospitals could have done a lot of things differently too.

How were the Emergency Departments traumatic?

- The triage nurses were terse and unfriendly
- No explanation of the process was given when we first arrived, aside from the fact that we would have to wait
- The waiting space was uncomfortable, dirty, and noisy
- There were no toys or books, aside from left-behind newspapers
- No support staff were available to help keep my son calm
- In the first hospital, EMS passed through the ED waiting room with patients on gurneys, which can be difficult/stressful to see, especially for children
- There were no psychiatry supports present in the ED, and the "on-call" team took approximately two or three hours to see us
- The security personnel did not appear to have de-escalation training, which could have alleviated the need for the use of restraints on a six-year-old
- The psychiatry team told me I should not have brought Myles to the ED, and that bringing him there likely traumatized him

How could SafER Space have made the Emergency Departments safer?

- Having peer support workers available to interface with us would have removed stress and provided a friendlier atmosphere
- Elevating the priority of mental health in the triage process may have brought the psychiatry team to our aid faster
- Having mental health clinicians as ED employees would have reduced the stressful wait time, and helped avoid escalation
- A waiting room that is calming and interesting to be in would have reduced the stress of waiting, especially for a child who may not really understand what is going on
- Ensuring all employees are trained on de-escalation methods, particularly security personnel, would have been helpful. Had the security personnel understood how traumatic being restrained would be for a child, and had they the skills to help de-escalate the situation, the experience might have been very different
- Arranging for appropriate follow-up supports and following up in the event the first option was not a fit to help navigate to a good fit would have been such an incredible help

2.0 Introduction

Myles Ahead's SafER Space is an initiative that **re-imagines hospital settings to co-design human-centred care that supports children and youth who are experiencing a mental health crisis**. To successfully make this a reality, SafER Space consists of a scalable framework, which includes six components (i.e., peer support, clinician support, training, triage and discharge, building design, and finishings design) of evidence-based best practices within three categories (i.e., people, process, and place), as outlined in Figure 1. In addition, there is a transformation toolkit to successfully implement and sustain the framework (Section 4.0).

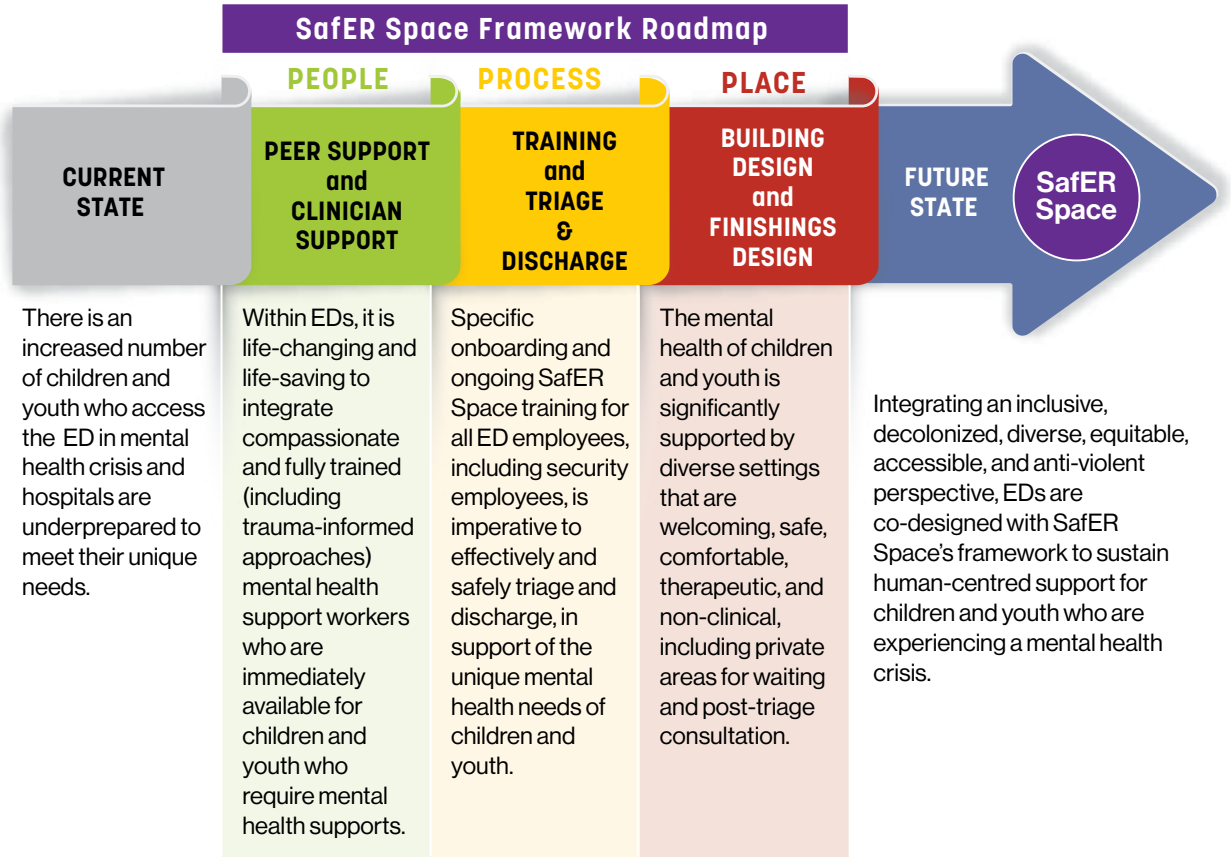


Figure 1. SafER Space Framework Roadmap.

Throughout Canada, while Myles Ahead's vision is to integrate SafER Space's framework within the entirety of all hospitals, the **initial focus is on EDs within children's hospitals.** Although the intent is to ultimately expand SafER Space beyond the ED, the letters "ER" are capitalized as a branded reference to the ED's colloquial name of Emergency Room. Based on Myles Ahead's research and findings, the SafER Space initiative has been **modelled after emerging best practices,** such as **EmPATH Units in California, Safe Crisis Support Space at The Prince Charles Hospital, and Safe Haven Café at St. Vincent's Hospital in Australia** (Section 3.0).

Throughout our research, we did not find similar spaces within Canadian hospital EDs that are designed to support children and youth mental health. This gap is an **urgent call-to-action for hospitals to transform by including a co-designed and human-centred experience that holistically supports child and youth mental health: This is SafER Space.** It is a response to close the gap with best practices of how people, processes, and places can, and must, positively impact children and youth mental health. Otherwise, EDs will continue to traumatize, whether intentional or not.

SafER Space's framework is based on a human-centred and integrated health services approach, which is an emerging best practice for mental health care,[17] to provide the right care, to the right person, at the right time.[18] In addition, SafER Space extends beyond the walls of the ED, as the framework includes the discharge conversation with follow up that integrates with community mental health services to support children and youth.

SafER Space fosters a greater sense of belonging and safety to better support children and youth who are experiencing a mental health crisis. The ED can be a traumatic experiencefor children and youth seeking mental health support, especially if they don't feel a sense of safety. [19] [20]

By integrating SafER Space's framework within EDs, children and youth can be better supported to feel safe and that their needs are important, offering genuine hope for them and their caregivers/families, instead of exacerbating an already challenging time.

17 Lyon, Aaron R., et al. "Designing the Future of Children's Mental Health Services." *Administration and Policy in Mental Health and Mental Health Services Research* 47 (2020): 735-751. https://doi.org/10.1007/s10488-020-01038-x

18 "Integrated Health Services - What and Why?" *World Health Organization International, World Health Organization*, May 2008, www.who.int/healthsystems/technical_brief_final.pdf, Accessed on March 18th, 2021.

19 Thielking, Megan. "'Traumatic as Hell': Patients Describe What It's like to Be Restrained in an ER." *STAT*, 24 Jan. 2020, www.statnews.com/2020/01/24/patients-restrained-in-the-er/.

20 Lerwick, Julie L. "Minimizing Pediatric Healthcare-Induced Anxiety and Trauma." *World journal of Clinical Pediatrics* 5.2 (2016): 143-150. https://doi.org/10.5409/wjcp.v5.i2.143.

3.0 Research & Findings

Myles Ahead is dedicated to advancing evidence-based best practices that support the mental health of children and youth in Canada. Given the systems in place to support child and youth mental health appear to be siloed, it is important that any initiative Myles Ahead prioritizes is not only **evidence-informed** but is also tested to help ensure that the work will be **useful and is not duplicating efforts** already underway.

To this end, after prioritizing the need to address mental health supports in EDs, Myles Ahead initiated research to **test the hypothesis** that leading, evidence-informed and integrated, mental health and building design practices are not currently being implemented in Canadian EDs. Myles Ahead's team conducted a **landscape assessment of current ED practices** within a sample of hospitals in Canada to gain insights into unique mental health practices that were already integrated. In addition, to inform hospital priority KPIs, Myles Ahead also reviewed 10 hospital performance scorecards and QIPs.

Landscape Assessment

The landscape assessment prioritized pediatric hospitals and the largest general hospitals, including a **review of over 140 programs within 40 hospitals and medical centres.** Findings from the assessment revealed 13 hospitals include one or more of SafER Space's framework categories of people, process, and place, beyond typical ED practices to better support mental health as follows:

People

- Eight general hospitals include at least one mental health professional in the ED, including one or more of the following:
  - Four include crisis intervention worker(s)
  - Three include emergency psychiatric services (may not include pediatric)
  - Two include a social worker at least some of the time
  - One includes peer support workers

- Three pediatric hospitals include at least one mental health professional in the ED:
  - Three pediatric hospitals have scheduled social worker hours (not 24/7)
  - One pediatric hospital ED includes a crisis intervention worker

Process

- Four general hospitals include unique mental health processes:
  - Two have mobile crisis units (may not include services for children)
  - One partners with a community mental health agency
  - One includes a pediatric urgent care program

- One pediatric hospital includes a partnership with a community mental health agency

Place

- Two general hospitals include separate mental health emergency spaces for children and for adults
- One pediatric hospital includes a separate mental health emergency space

Based on the assessment, the Myles Ahead team concluded that the hypothesis is accurate: leading, evidence-informed and integrated, mental health and building design practices are not currently being implemented in Canadian EDs.

Global Literature Review

In addition, Myles Ahead's team **conducted a global literature review of emerging best ED mental health designs and practices.** This literature review included over 50 publications from peer reviewed journals in the fields of psychology, psychiatry, pediatrics, government and hospital data sources, industry publications, and news articles. (At the time of this writing, no published information was available in relation to current research underway, such as Dr. Daphne Korsczak's "I Am Safe" pilot, which is being tested at 6 hospitals and provides short-term post-discharge mental health follow-up supports.) Evidence from this literature review has informed the creation of SafER Space's framework and transformation toolkit.

Interviews with Subject Matter Experts

After completing the secondary research phase, Myles Ahead's team also conducted interviews to learn from leaders in the field of advancing mental health care within hospitals. Interviewees provided insights into the research and first-hand experiences associated with implementing leading mental health practices within the hospital ED setting. The Canadian interviewees also helped to ensure there is no duplication of efforts within Canada to create a similar framework like SafER Space, in addition to its transformation toolkit. We gratefully acknowledge the practitioners for their contributions within the Acknowledgements section (after Section 6.0).

By triangulating the landscape assessment with news articles and input from subject matter experts, three instances of innovative practices to advance mental health practices in EDs beyond Code White, workplace violence related rapid assessment tools and training were identified as follows:

- St. Joseph's Hospital (Ontario), Mental Health Emergency Services Unit
- Joseph Brant Hospital (Ontario), Psychiatric Emergency Service
- Credit Valley Hospital (Ontario), RBC Paediatric Urgent Care Mental Health Program
- Rockyview General Hospital (Alberta), Psychiatry Emergency Room Outreach

It is important to note the Centre for Child & Adolescent Mental Health is currently under construction by Alberta Children's Hospital Foundation and is scheduled to open in the autumn of 2022 and will likely include best evidence-informed practices across people, process, and place.

Research Limitations

The intention of the landscape assessment was to gain insights into current practices within pediatric and larger hospitals in relation to mental health supports available as part of the ED to test the hypothesis that leading, evidence-informed and integrated, mental health and building design practices are not currently being implemented in Canadian EDs. With over 1,200 hospitals in Canada, the research was limited to pediatric hospitals and the largest, which is not considered to be a comprehensive assessment of all services across all hospitals. In addition to limitations associated with the sample size, the availability of web-based information presented a study limitation as follows:

- The level of detail describing current mental health resourcing ED practices was often vague; and
- Aside from noting separate emergency mental health spaces, the building design and finishings were seldom mentioned; and
- Finding hospital scorecards, KPIs and QIPs required considerable time; as a result, Myles Ahead limited the number of scorecards to review to 10.

While the global literature provided a wealth of information in support of developing SafER Space's framework and transformation toolkit, it is not intended to be an exhaustive list of all research.

Summary

Overall, Myles Ahead's team concluded that the landscape assessment, literature review, and subject matter expert interviews provided a compelling case in support of co-creating SafER Space's framework and transformation toolkit. Evidence indicates the components outlined in the framework can have a positive impact, not only for children, youth, and their caregivers/families accessing mental health supports through the ED, but also for the health and wellbeing of hospital employees and other ED visitors.

4.0 Framework

SafER Space's scalable framework is **enabled by technology,** whether analog and/or digital, depending on the needs of a given context for optimum delivery and accessibility. In addition, foundational to the framework, there are **two guiding principles:**

1. Integrate perspectives and experiences that genuinely and meaningfully reflect **inclusion, decolonization, diversity, equity, accessibility, and anti-violence,** especially with those who experience (or have experienced) colonization, racism, sexism, stigmatization, marginalization, bullying, lack of representation, lack of supports, exclusion and/or other forms of oppression; and
2. **Co-design with those who have direct experience with child and youth mental health,** including youth, caregivers/families, and professionals within EDs.

As illustrated in Figure 2, reflecting SafER Space's integrated or holistic approach, the framework's model is a circle. Surrounding the model is **Community Mental Health Supports,** given this is an **integral connection or partnership with EDs** to effectively serve the mental health needs of children and youth. In addition, the framework consists of **six components** (i.e., peer support, clinician support, training, triage and discharge, building design, and finishings design) that are **organized within three categories** (i.e., people, process, and place). Recognizing that the co-design of a SafER Space is an ongoing journey and varies depending on the unique needs of the community of people that a hospital serves, **each component is differentiated by Phase 1, Phase 2, and Phase 3.** Each phase includes descriptions of evidence-based best practices for establishing and advancing a particular phase.

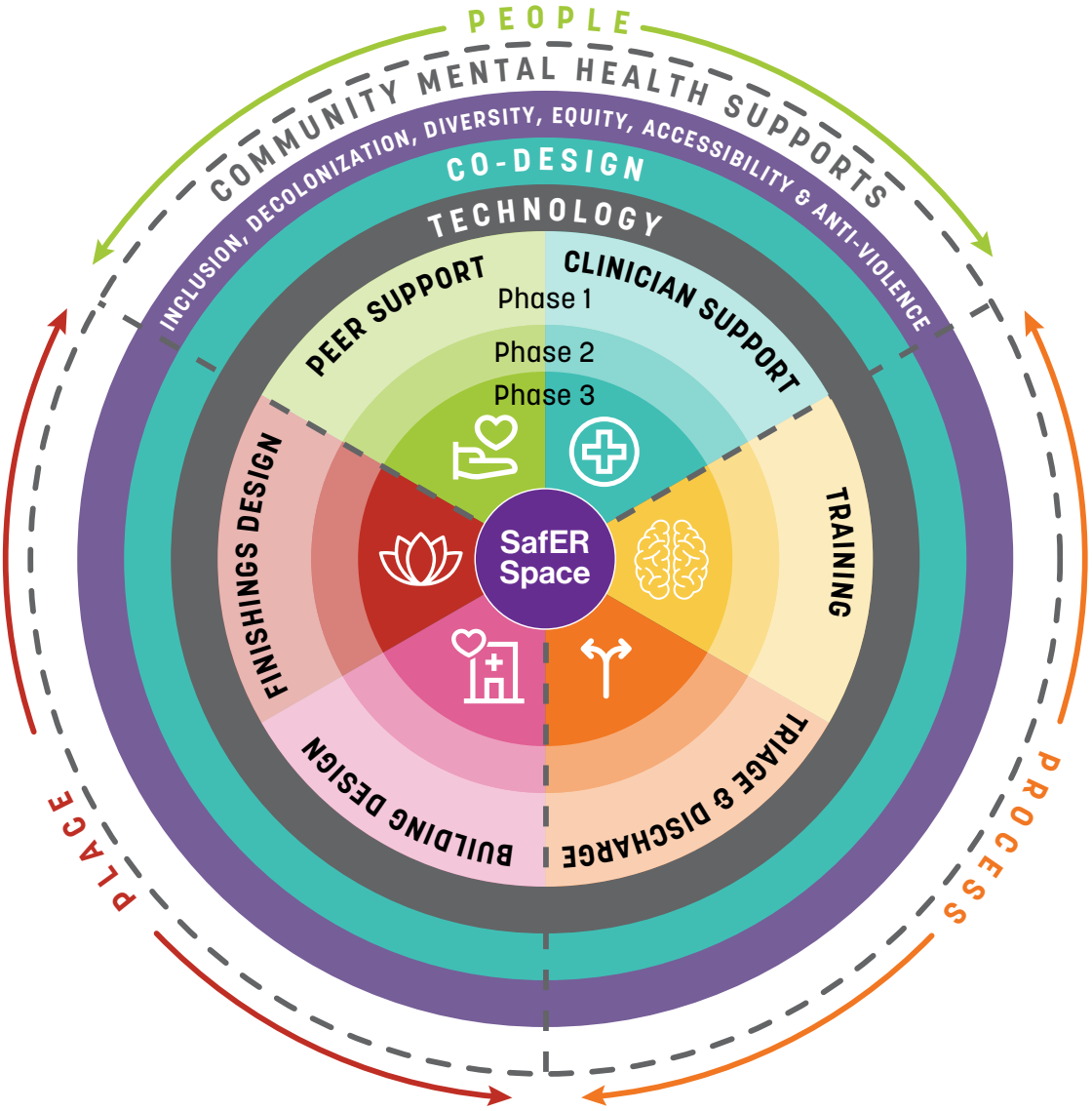
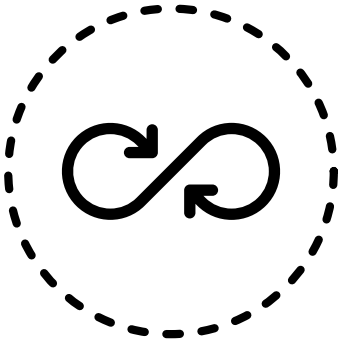


Figure 2. SafER Space Framework Model.

The following sections provide more detail for considerations regarding Community Mental Health Supports and each of the framework's six components, including recommended, evidence-based, best practices for Phases 1, 2 and 3.

4.1 Community Mental Health Supports



A human-centred approach to mental health supports for children and youth must importantly extend beyond EDs and in-hospital treatments to include a warm handover to wraparound services within the community for post-discharge continuity of care.

Warm handovers play an important role in reducing the emotional stress associated with transitioning from one service provider to another by removing the need and frequency of repeating personal and painful experiences to multiple audiences. This can be especially important to help build trust by reducing the harmful effects for a child or youth when their story is being retold in front of them by their parent or caregiver. In addition to the anecdotal qualitative benefits that warm handovers have for patients, they have also been shown to reduce appointment cancelations, expedite access to services, and improve mental health outcomes.[21]

The wraparound continuity of care concept has gained recognition for supporting protective and positive outcomes for children and youth who require intensive mental health supports.[22] Without consideration for post-discharge continuity of care, it increases the likelihood of adverse outcomes, such as self-harm, suicide, and repeat ED visits.

Although the benefits of warm handovers and the wraparound approach have been well-documented, they have yet to be adopted broadly or at the system level (i.e., primary health organizations, hospitals, community mental health service agencies, and government organizations).

Implementing this approach in real terms requires significant change management considerations for hospitals and community mental health agencies.

With the pressing business of saving lives and treating the growing mental health needs of children and youth, hospitals and community mental health support agencies do not appear to have the resources to dedicate towards strategic system-level solutions, such as the wraparound process and leveraging cross-pollination opportunities of peer support workers from community mental health agencies. While tactical details require customization for the unique needs and attributes associated with integrating continuity of care pathway systems between hospitals and community mental health support agencies to enable wraparound services, SafER Space's transformation toolkit includes fundamental change management tools, steps, and processes that support effective and sustainable change (Appendices).

Specifically, Appendix B contains question prompts for technological considerations, such as interface systems (e.g., patient data, SafER Space integration, information exchange between the hospital and community mental health support

21 Young, Nicholas D., et al. "Warm handoff, or Cold Shoulder? An Analysis of Handoffs for Primary Care Behavioral Health Consultation on Patient Engagement and Systems Utilization." *Clinical Practice in Pediatric Psychology* 8.3 (2020): 241-246. https://doi.org/10.1037/cpp0000360.

22 Bruns, Eric J., et al. "Ten Principles of the Wraparound Process." *Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University*, (2004). https://www.researchgate.net/publication/265616599_Ten_Principles_of_the_Wraparound_Process. .

agencies), and legal considerations, such as legal agreements between the hospital and the community mental health support agencies to support the continuity of care. In addition to creating agreements and technology solutions to facilitate the availability of warm handovers and wraparound services, the design and integration of its process would need to be tailored to reflect the needs of the people being served, clinicians, and administrators. Examples of other considerations include privacy protocols when sharing personal information, treatment plans, and other relevant data shared between hospitals and community mental health support agencies.

4.2 People: Peer Support Workers

Vision Statement: Compassionate peer support workers are **fully trained, including trauma-informed approaches, and integrated within the emergency department** to readily support children and youth who are experiencing a mental health crisis.

Table 1: A Phased Approach of SafER Space's Implementation and Sustainment for Peer Support

Phase 1	Phase 2	Phase 3
Compassionate peer support workers (e.g., parents/caregivers and young adults with lived experience) are fully trained, have clear accountabilities, and are available within the ED **during known peak hours and on-call during off-peak hours** to support children and youth, including their parents/caregivers, who are experiencing a mental health crisis.	Compassionate peer support workers are fully trained and **integrated** within the ED **during known peak hours and on-call during off-peak hours** to support children and youth, including their parents/caregivers, who are experiencing a mental health crisis.	Compassionate peer support workers are fully trained and **integrated** within the ED **24/7** to support children and youth, including their parents/caregivers, who are experiencing a mental health crisis.

As a new role within the ED, the value of peer support workers is often not recognized until experienced first-hand by the ED team. According to Dr. Scott Zeller, who led the development of the EmPATH unit concept gaining traction in the USA, "Peer Support Workers are worth ten times their weight in gold. By leveraging their own personal lived experience with mental health challenges, **Peer Support Workers are able to more immediately relate and provide compassionate support for patients in mental health distress."**

There is a strong body of evidence that demonstrates having fully trained peer support workers (e.g., parents/caregivers and young adults with lived experience) integrated within the ED has multiple benefits. Beyond positively impacting the experience of children and youth in mental health crisis, peer support workers can help parents and caregivers interface with ED employees and assist ED staff by monitoring patients and their status. Peer support workers help to build trust and provide insights that only those with lived experience can truly understand...

Peer support programs make a positive difference...

ACTIONS:

Mount Sinai Hospital's **Pathway to Peers (P2P) program is an innovative, patient-centred, young adult focused complement to care**. Within the P2P team, peer support workers have supported over 600 young adults in the ED since the program's launch in May 2020.

RESULTS:

P2P team members have been **recognized as experts and advocates** within the broader hospital system, including **overwhelmingly positive feedback**.

Reference: "Peer Support Program Supports Youth Through Mental Health and Addictions Crises in the ED." *Family and Community Medicine, University of Toronto*, 4 February 2021, https://dfcm.utoronto.ca/news/peer-support-program-supports-youth-through-mental-health-and-addictions-crises-ed

Studies show...

Since the implementation of a peer support program in 6 different hospital EDs, there was a 35% reduction in ED visits, a 38% reduction in hospitalizations, and 6% reduction in 30-day readmissions.

Reference: Kaur, M., & Melville Jr, R. H. "Emergency Department Peer Support Specialist Program." *Psychiatric Services*, 72.2 (2021): 230-230, https://ps.psychiatryonline.org/doi/10.1176/appi.ps.72102

Peer Support Benefits:

The **Mental Health Commission of Canada has identified that peer support is effective**, given people with lived experience of mental health challenges can offer huge benefits to each other, including the **development of personal resourcefulness and self-belief, which improves people's lives and reduces the use of formal mental health, medical, and social services**.

820+

individuals across Canada

Findings are based on reports from over 600 individuals from across Canada who took part in focus groups and interviews, in addition to another 220 people who offered their input through written and online surveys.

Reference: Cyr, Céline, et al. "Making the Case for Peer Support." *Mental Health Commission of Canada*, 29 July 2016, https://mentalhealthcommission.ca/resource/making-the-case-for-peer-support

4.3 People: Mental Health Clinicians

Vision Statement: Mental health clinicians are **fully integrated members of the ED team and immediately** available to support children and youth who are experiencing a mental health crisis.

Table 2: A Phased Approach of SafER Space's Implementation and Sustainment for Clinician Support

Phase 1	Phase 2	Phase 3
Compassionate mental health clinicians (e.g., psychiatrist, psychologist, social workers, and psychiatric nurses) are fully trained and available within the ED **during known peak hours and on-call during off-peak hours** to support children and youth, including their parents/caregivers, who are experiencing a mental health crisis. Upon discharge of patients, they are provided a curated and current list of available mental health service providers in the community.	Compassionate mental health clinicians are fully trained and **integrated** within the ED **during known peak hours and on-call during off-peak hours** to support children and youth, including their parents/caregivers, who are experiencing a mental health crisis. In addition, **referrals are made to available mental health service providers** in the community, while also considering wait times and what services are the most suitable for the patient.	Compassionate mental health clinicians are fully trained and **integrated** within the ED to provide **24/7** support. In addition, upon discharge, **clinicians directly connect patients with suitable and available mental health service providers** in the community and **follow up within 24-48 hours** to confirm successful access of community supports or otherwise provide alternative options.

When initially created, EDs were designed, equipped, and staffed to provide urgent medical support for physical illness and injury. People experiencing mental health distress are increasingly turning to the ED for support, and mental health clinicians are often on-call but not available to support patients in a timely manner. For example, as one patient describes, "I had very little care for a lot of difficult symptoms until I was in crisis. **My family took me to the ER, where I waited for many hours to see someone."**[23] Providing **timely and appropriate clinical mental health supports** are critical to relieve the distress for which patients are seeking help.

23 Butler, A., et al. "Towards Quality Mental Health Services in Canada: A Comparison of Performance Indicators Across 5 Provinces." Vancouver BC: Centre for Applied Research in Mental Health & Addiction (CARMHA), (2017): 1–134. https://www.sfu.ca/content/dam/sfu/carmha/resources/2017-toward-quality-mh/prov_indic_technical_report_final.pdf.

It is proven that when compassionate mental health clinicians are an integral part of the ED, this can have a significantly positive impact on the multidimensional wellness of children and youth who are experiencing a mental health crisis...

Empathetic models of care can make a positive difference...

ACTIONS:

Integrating a more empathetic model of care, like **EmPATH**, for people who are experiencing a behavioural health crisis at an ED.

RESULTS:

75%

decrease in hospitalizations when using an empathetic model of care

80%

of patients go home within 16 hours when seen with an empathetic model of care

Reference: Brown, Denise. "EmPATH: Stopping the Dehumanization of Behavioural Health Patients in Emergency Departments." *STAT*, 2 July 2019, https://www.statnews.com/2019/07/02/empath-model-behavioral-health-emergency-departments

Studies show...

A review of physician-patient communication (including compassionate care) and health outcomes of 21 studies showed a **positive relationship between compassionate care and symptom resolution, function, physiologic measures, and emotional health.**

Reference: Stewart, Moira A. "Effective Physician-Patient Communication and Health Outcomes: A Review." *Canadian Medical Association Journal* 152.9 (1995): 1423. PMC1337906

A pivotal issue:

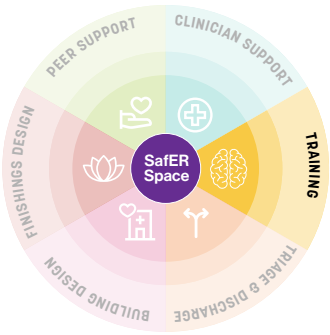
Lack of effective communication and empathy from healthcare providers and administrative staff in the ED.

A pivotal approach:

Both youth and parents noted that effective communication and demonstrated empathy contributed to improved patient experiences.

Reference: Campbell, Leslie Anne, et al. "Opening the Door: Inviting Youth and Parent Perspectives on Youth Mental Health Emergency Department Use." *Research Involvement and Engagement* 6.26 (2020): 1-8. https://doi.org/10.1186/s40900-020-00204-7

4.4 Process: Training



Vision Statement: SafER Space training and processes are fully **integrated into the hospital's management system** and all emergency department employees participate in the training modules that enable them to effectively support children and youth who are experiencing a mental health crisis.

Table 3: A Phased Approach of SafER Space's Implementation and Sustainment for Training

Phase 1	Phase 2	Phase 3
All ED employees, including security employees, are provided with an overview of SafER Space, and they **complete foundational training** and refresher modules that build awareness and understanding of important mental health considerations, such as suicidality, life promotion, empathy, and compassion. Examples of training modules include De-escalation, Risk Screening, **Suicide Awareness & Prevention,** and Mental Health First Aid for Adults Who Interact with Children & Youth. In addition, Peer Support Workers receive specialized training certification for working within the ED by an accredited organization, such as Peer Support Canada.	Beyond Phase 1, peer support workers and mental health clinicians complete comprehensive **SafER Space training modules that are customized** for the ED. For example: • curricula that supports intercultural competence and decolonization co-designed in partnership with Indigenous Peoples • curricula that develops greater awareness and understanding of human-centred skills (e.g., IDEA, gender identity, 2SLGBTQ+) A resource is accountable to **coordinate training, KPI monitoring, and ongoing updates** for SafER Space.	Beyond Phases 1 and 2, **all ED employees are values-based hires. SafER Space's processes are fully integrated** into the hospital's management system (i.e., learning and performance management system), including: • training • KPI monitoring • continuity of care connections to community mental health agencies This integration enables the ongoing identification of improvements that support a **learning organization**.

It is important to review and reflect on training regularly. Fran Timmins of St. Vincent Hospital in Melbourne noted they have added **Trauma-Informed** to the Introduction, Situation, Background, Assessment, and Recommendation patient interface communication protocol, called ISBART. This addition was made to "reflect the criticality of having patient interactions be **trauma-informed**."

When all **ED employees complete training** that build awareness and understanding of important mental health considerations, such as trauma-informed suicide awareness and prevention training, they are better able to support children and youth who are experiencing a mental health crisis. Integrating the SafER Space training into existing learning systems, which reflect the needs of the hospital population being served, will support a learning organization. Recommended training includes Trauma-Informed De-Escalation and Safety (TIDES), Mental Health First Aid for Adults who Interact with Youth, ISBAR, Suicide Awareness and Prevention, among others...

ISBAR COMMUNICATION TOOL
for effective ED handovers

- **I** — **Introduction** - identify yourself and state patient's details
- **S** — **Situation** - state if the situation is urgent; identify current symptoms and clinical needs
- **B** — **Background** - diagnosis; comorbidities; other health issues; lab results; medications; allergies
- **A** — **Assessment** - provide an interpretation or summary of your assessment
- **R** — **Recommendation** - state a clear recommendation with a time frame

Reference: "Interprofessional Communication in Nursing: Resources to Facilitate Interprofessional Communication." *Introduction to Communication in Nursing*, edited by Jennifer Lapum, Dona St-Amant, Michelle Hughes and Joy Garmaise-Yee, X University Pressbooks. https://pressbooks.library.ryerson.ca/communicationnursing/chapter/resources-to-facilitate-interprofessional-communication

14-Hour Training Course:

MENTAL HEALTH FIRST AID (MHFA)
for Adults who Interact with Youth

- **A** — **Assess** the risk of suicide and/or harm
- **L** — **Listen** non-judgmentally
- **G** — **Give** reassurance
- **E** — **Encourage** professional support
- **E** — **Encourage** other supports

The training course is designed by the Mental Health Commission of Canada and includes the **ALGEE framework to have a confident conversation about mental health with youth.**

Reference: "Mental Health First Aid Canada: Adults who Interact with Youth." *Mental Health Commission of Canada*, https://www.mhfa.ca/en/course-type/adults-who-interact-youth

The Empathy Toy is an award-winning **educational tool** that **empowers people to better understand themselves and each other.**

Reference: "The Empathy Toy®" *Twenty One Toys*, https://twentyonetoys.com/pages/empathy-toy

4.5 Process: Triage & Discharge

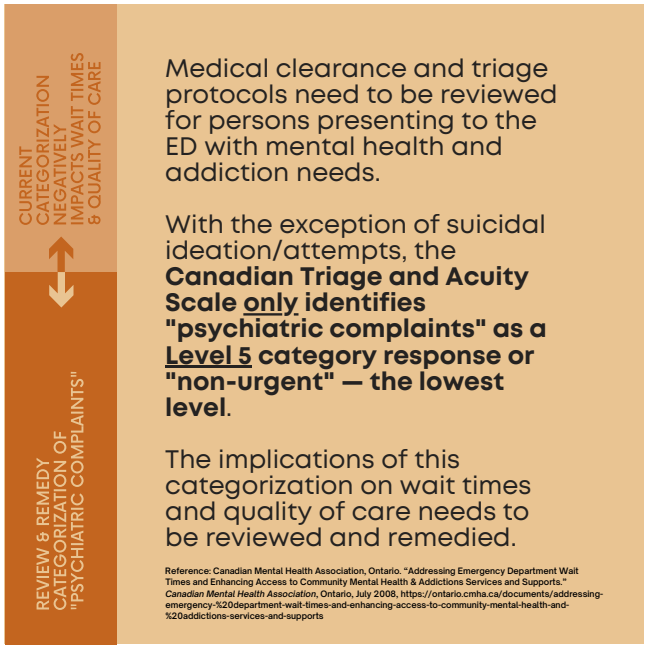
Vision Statement: The emergency department's triage and discharge follow-up processes prioritize mental health at the same level as physical health.

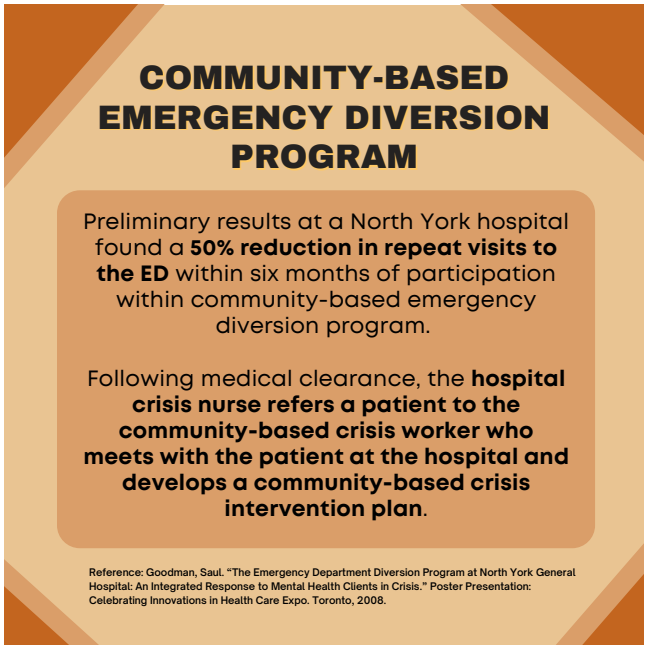
Table 4: A Phased Approach of SafER Space's Implementation and Sustainment for Triage & Discharge

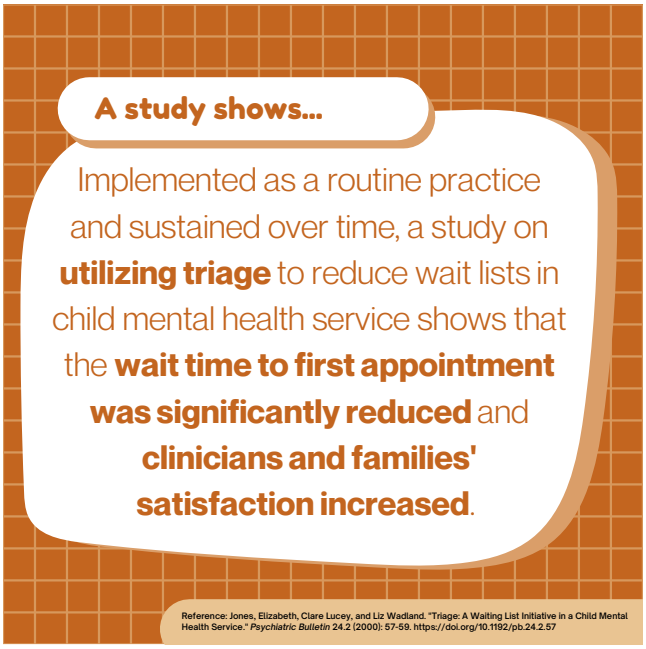
Phase 1	Phase 2	Phase 3
The triage process **prioritizes access** to mental health clinicians and peer support workers **during known peak hours.** To advance the triage process toward a SafER Space, consider the following: • clear protocols and priority assessment criteria to access mental health supports are in place • all triage and security employees are familiar with SafER Space process The discharge follow-up process includes establishing appointments with community mental health support agencies for continuity of care within 24 hours.	With the integration of mental health support workers in the ED **during known peak hours,** the triage process enables **immediate access** to mental health supports. To advance the triage process toward a SafER Space beyond Phase 1, consider having **peer support workers** as part of the **triage process** to provide immediate support to families while consult process is established. The discharge follow-up process is integrated into the system to help ensure appointments are scheduled with community mental health support agencies for continuity of care.	With the integration of mental health support workers in the ED, the triage process enables **immediate access** to mental health supports **24/7.** Beyond Phases 1 and 2, the **SafER Space triage and discharge follow-up process is fully integrated** into the hospital's operations / management system (i.e., effectiveness of the triage process is independent of specific clinicians and relationships). There are **protocols across services** so that ambulance and other first responders or community partners (e.g., mobile crisis units) are aware of the SafER Space process.

Integrating mental health supports within the ED and its triage and discharge processes can be lifesaving. "My daughter, Breana, died within 4 days after being discharged from the ED. I cannot emphasize the importance of this enough," says Martha McGroarty, **"if there had been continuity of care for my daughter Breana, I believe that would have made all the difference and she would be with us today."**

When SafER Space is fully integrated into the triage and discharge process, including supports from mental health clinicians and peer support workers (e.g., young adults, parents/caregivers with lived/living experience), it helps to ensure that suitable supports are immediately available for children and youth who are experiencing a mental health crisis...







4.6 Place: Building Design

Vision Statement: The ecosystem of the emergency department provides a **calming and therapeutic SafER Space for everyone,** reducing the risk of escalation and trauma, enhancing patient interfaces, and generally promoting mental health.

Table 5: A Phased Approach of SafER Space's Implementation and Sustainment for Building Design

Phase 1	Phase 2	Phase 3
Easily implementable and low-cost options for the ED waiting room and patient consult rooms include the following: • use of soft-structured partitions to create semi-private alcoves that attenuate noise • aquarium • living wall feature • green exit signs instead of red	Beyond Phase 1, consider **creating zones** and including the following: • water feature(s) • zones of optional therapeutic blue lighting (adjustable) • built-in interactive touchscreen devices with multiple calming program options, such as soundscapes (e.g., Nature), counting games, art drawing, and puzzles • use of noise-attenuating features and materials	A **full redesign** of the ED that holistically integrates therapeutic and natural elements **throughout the waiting room and patient consult rooms.** If practical, the redesign enables physical or visual **access to calming outdoor areas** that are "connected" by a digital display and intercom system for communications (e.g., notifications for patients to see mental health clinicians).

"The mock ups for the patient consult room in the SafER Space proposal blew me away," Marlo Miazga shared, **"A space like this would have been a game changer for my child in their visit to the emergency room.** Its thoughtful design and therapeutic details suggest that the adults in the room believe that their mental distress is a crisis...and that help is on the way. It would have immediately de-escalated our situation and supported us to make better choices for our child's care. We all would have felt safer and not like we had done something wrong." Mars Miazga-Kaufman died by suicide in November of 2020.

When co-regulation informs the design of the space, EDs can become welcoming, calming, safe, comfortable, and therapeutic. For children and youth who are in mental health crisis, a co-regulated ED design can have a significantly beneficial effect on their mental wellness...

Art depicting nature scenes has been shown to help **reduce patients' agitation and anxiety** in healthcare settings.

Reference: Nanda, Upali, et al. "Effect of Visual Art on Patient Anxiety and Agitation in a Mental Health Facility and Implications for the Business Case." *Journal of Psychiatric and Mental Health Nursing* 18.5 (2011): 386-393. https://doi.org/10.1111/j.1365-2850.2010.01682.x

A study at an inpatient psychiatric hospital showed that **changes to the physical environment**, such as **painting with warm colours, placement of plants, and rearrangements of furniture** to facilitate increased patient and patient-staff interaction, were uniquely associated with a **significant reduction in rate of seclusion and restraint**.

Reference: Borckardt, Jeffrey J., et al. "Systematic Investigation of Initiatives to Reduce Seclusion and Restraint in a State Psychiatric Hospital." *Psychiatric Services* 62.5 (2011): 477-483. https://doi.org/10.1176/ps.62.5.pss6205_0477

From a patient-experience standpoint, **art can promote feelings of tranquillity, instil a sense of home, and positively distract them from uncomfortable situations**.

Reference: Nielsen, Stine L., et al. "How Do Patients Actually Experience and Use Art in Hospitals? The Significance of Interaction: A User-Oriented Experimental Case Study." *International Journal of Qualitative Studies on Health and Well-Being* 12.1 (2017): 1267343. https://doi.org/10.1080/17482631.2016.1267343

4.7 Place: Finishings Design

Vision Statement: The emergency department's ecology instills a sense of calm, safety, and comfort through the infusion of **finishings** that **support the mental stability and wellbeing** of children and youth.

Table 6: A Phased Approach of SafER Space's Implementation and Sustainment for Finishings Design

Phase 1	Phase 2	Phase 3
Easily implementable and low-cost options for the ED waiting room and patient consult rooms, as appropriate, include the following: • soothing paint tones • calming and engaging art (e.g., wall art, murals) • incorporate elements of nature in the flooring, wall panelling, and wherever possible • live plants and living wall features • soft furnishings to support noise attenuation • sensory toys and other occupational therapy devices (e.g., weighted blankets and noise-cancelling headphones)	Beyond Phase 1, consider the following: • **multiple seating options,** such as modular, high-back couches, recliners, bean bags, and hug chairs to help provide a feeling of safety • **multimedia** support items available for all ages, like picture and reading books, colouring books, sensory toys, and puzzles • patient consult rooms have **wall and/or ceiling murals**	The ED is fully redesigned, including **human-centred finishings** that complement the space, in **support of trauma-informed care** for children and youth.

Walking into the hospital ED can be so scary for a child. Damion Nurse, a member of Myles Ahead's team, reflected on his experience as a parent going to the ED. "I remember my son running away in fear when I brought him to the hospital while he was in crisis. I truly believe **if the ED was designed to help children and youth feel calmer, my son would have felt so much better about getting the help we needed."**

Entering an ED that is infused with multidimensional wellness finishings can have an immediate stabilizing effect for somebody who is experiencing a mental health crisis. EDs that are **welcoming, safe, comfortable, and therapeutic** can have a significantly positive impact on children and youth, which also translates to a more positive experience for employees in the SafER Space...

Consider accessible courtyard & nature window views at ED...

Psychiatric wards designed to include communal spaces to regulate relationships, low social density, noise reduction, accessible garden, nature window views, art, and daylight exposure resulted in a **50% decline in restraint use**.

Reference: Ulrich, Roger S., et al. "Psychiatric Ward Design Can Reduce Aggressive Behavior." *Journal of Environmental Psychology* 57 (2018): 53-66. https://doi.org/10.1016/j.jenvp.2018.05.002

Consider a variety of seating options in ED waiting room...

Having **a sensory or comfort room to provide a soothing, peaceful space, and the use of sensory modulation techniques to assist with emotion regulation** have been identified as contributing to the **reduction of seclusion and restraint**.

Reference: Champagne, Tina, and Nan Stromberg. "Sensory Approaches in Inpatient Psychiatric Settings: Innovative Alternatives to Seclusion and Restraint." *Journal of Psychosocial Nursing and Mental Health Services* 42.9 (2004): 34-44. https://doi.org/10.3928/02793695-20040901-06

Consider sensory rooms for Patient Consult Rooms at ED...

The use of a sensory room in an acute inpatient psychiatric unit was found to **help reduce distress and disturbed behaviour**. Using weighted blankets were particularly **helpful for self-soothing**.

Reference: Novak, Theresa, et al. "Pilot Study of a Sensory Room in an Acute Inpatient Psychiatric Unit." *Australasian Psychiatry* 20.5 (2012): 401-406. https://doi.org/10.1177/1039856212459585

4.8 Place: Emergency Departments Reimagined

Examples of the aspirational Phase 3 design of SafER Space's building and finishings components are included in this section. These examples illustrate enhancement opportunities for EDs, such as including a **variety of options for seating comfort, biophilia,** and **natural colour palettes** that are beneficial to the patient's experience. Indeed, the evidence-informed SafER Space recommendations to reimagine the ecology of EDs will not only enhance the patient's experience, it will reduce workplace violence and improve employee satisfaction.

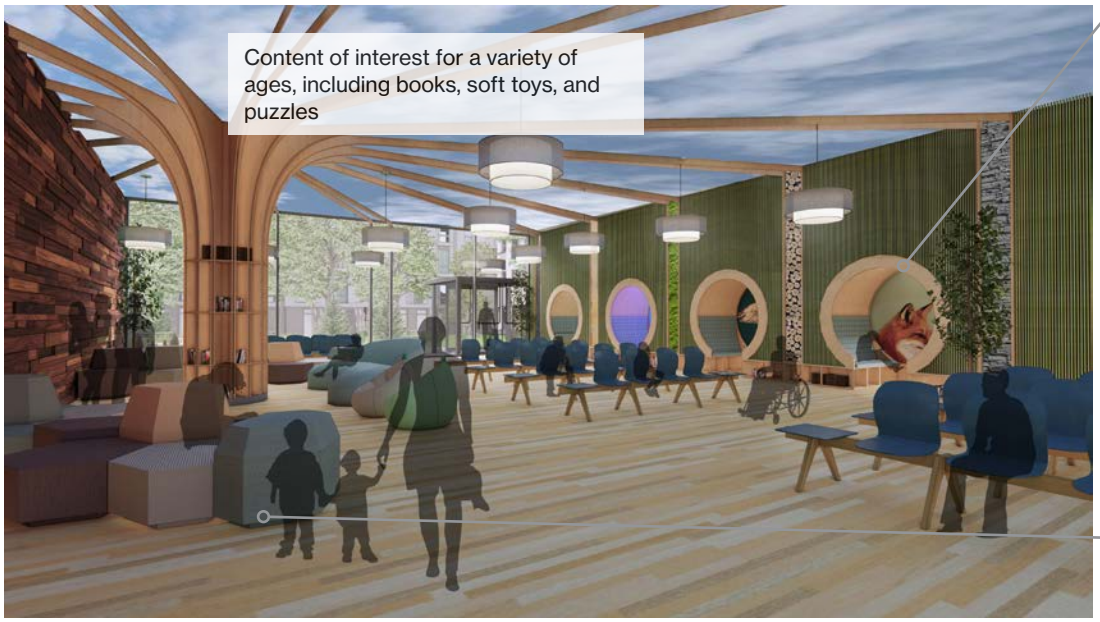


Figure 3. Panoramic view of waiting room within a reimagined ED

Within Figure 3, the biophilic design features include the following:

- the 'tree' focal point and how its branches reach across the field of view, with lights dangling like fruit or flowers
- including the exterior courtyard as part of the waiting room
- integrating additional natural materials through 'branch extension' feature wall inserts along the alcove wall (i.e., water, earth represented by sand, landscape represented by moss, trees represented by log-faces, and mountains/stones represented by slate).

Figure 4. View of alcove wall in a waiting room within a reimagined ED

In addition to the alcoves providing quiet spaces with reduced sensory stressors, the animal murals and natural colour palettes help to create a therapeutic atmosphere. Regarding symbolism, the circles are integrated to recognize the sacred and healing powers of connectedness or community, particularly regarding Indigenous Peoples' worldviews of Healing Circles.[24]

Figure 5. Close-up view of an alcove in a waiting room within a reimagined ED

Providing access to an exterior courtyard as part of the waiting room can have a very calming effect for children and youth who are in crisis. Having outdoor features like water fountains, therapeutic gardens, intercultural inclusions (e.g., totem pole), and greenery available for peer support workers to use in support of patient stabilization, can improve the patient's experience, reduce incidence of workplace violence, and enhance employee satisfaction in the ED.

24 Stevenson, Jean. "The Circle of Healing." *Native Social Work Journal* 2.1 (1999): 8-21. https://iaac-aeic.gc.ca/050/documents/p63928/92023E.pdf.

Figure 6. View of accessible outdoor courtyard from within a reimagined ED waiting room

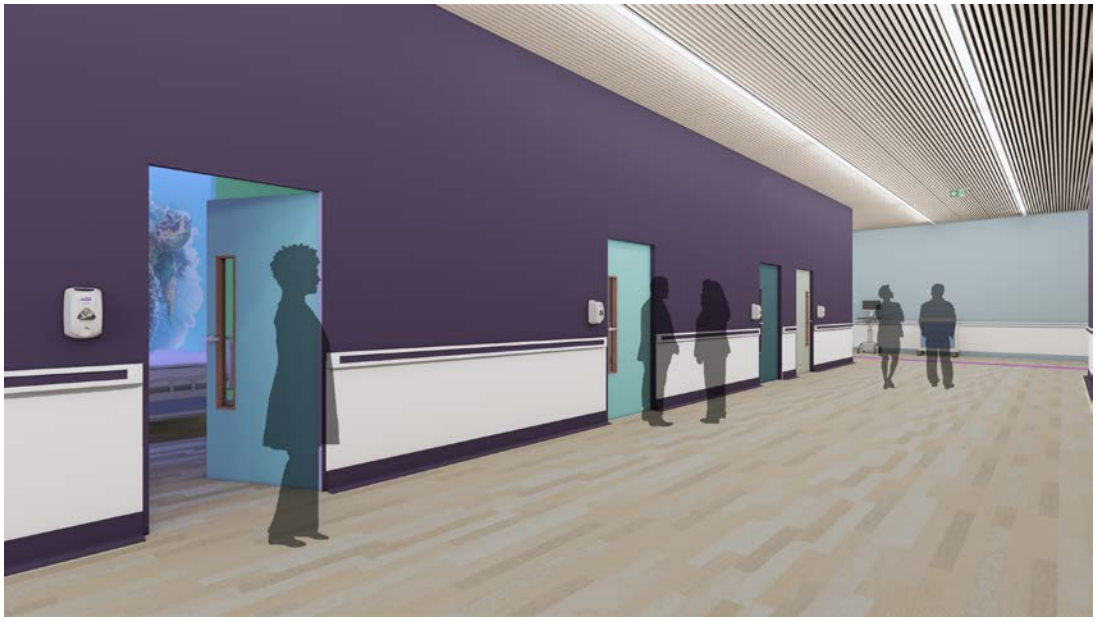


Figure 7. View of hallway to patient consult rooms within a reimagined ED

Within the patient consult room, there could be a television with default programming of a calming aquarium loop and there could be lighting controls that are dimmable and include blue healing lights.

Figure 8. View of a patient consult room within a reimagined ED – only blue lights are on

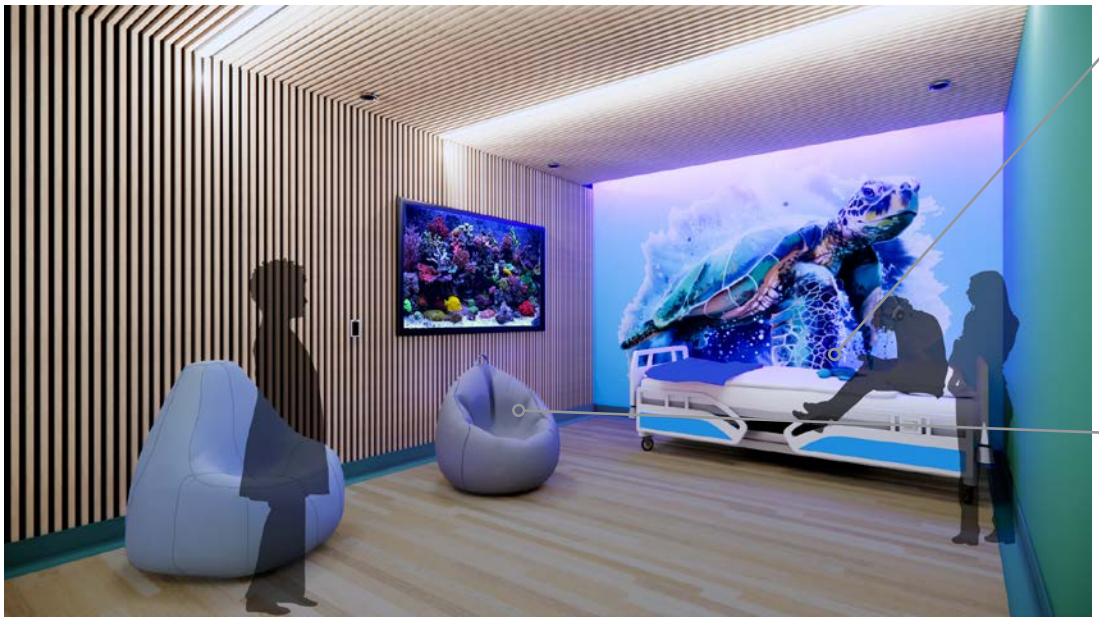


Figure 9. View of a patient consult room within a reimagined ED – all lights are on

4.9 Benefits and Performance Indicators

To identify the benefits that advancing EDs toward SafER Spaces would have for hospitals, it is important to consider the current state of ED employees and patients' experiences, existing processes, and spatial design. To support this effort, as part of the environmental scan (Section 3.0), scorecard key performance indicator (KPI) metrics and quality improvement plans (QIPs) were reviewed where possible.[25] The intention of the environmental scan was to identify noteworthy instances of mental health innovations in hospital EDs, explore how hospitals measure KPIs that would have a high probability relation to mental health, and what improvement plans are being implemented to respond to areas with performance challenges.

With the exclusion of mandatory compliance KPIs, there appears to be a lack of coordination and consistency with other performance monitoring indicators and QIPs. The mandatory compliance KPIs do, however, present a compelling case to improve workplace violence incident reporting and reduce the occurrence of those incidents. While the effectiveness of increasing workplace violence incident reporting will introduce data interpretation difficulties to discern whether workplace violence mitigation QIPs are effective, the QIPs nonetheless introduce some consistency in efforts to have healthcare employees assess the likelihood of patient escalation to violence. The identification of escalation risks empowers employee awareness to help mitigate the risks. In addition, the QIPs often included advancing Code White training and, in two instances, the provision of peer support for hospital employees. The sharing of performance improvement lessons across the industry does not appear to be a standard practice.[26]

KPI and QIP consistency notwithstanding, the reality is that hospital employees face disproportionate instances of workplace violence[27] and high rates of psychological distress and professional burnout.[28] [29] The impact of hospital employees' burnout and lost-time injuries goes beyond the economics of workplace incident insurance claims and lost-time pay from an organizational perspective. That is, these impacts adversely fuel a feedback loop that can cause ripple effects that harm the workforce culture and employees' quality of life. Few would argue that the workplace violence KPI is not a priority performance area to improve upon.

25 Given the challenge finding performance scorecards and QIPs through an internet search, Myles Ahead reviewed related information from 10 hospitals in 4 provinces, including (from west to east) BC Children's Hospital, Alberta Children's Hospital, McMaster's Children's Hospital, SickKids, Sunnybrook Hospital, Children's Hospital of Eastern Ontario, Hospital Montfort, Dr. Everette Chalmers Regional Hospital, Upper River Valley Hospital, and St. Joseph's Hospital (NB).

26 Backman, Chantal, Saskia Vanderloo, and Alan John Forster. "Measuring and Improving Quality in University Hospitals in Canada: The Collaborative for Excellence in Healthcare Quality." *Health Policy* 120.9 (2016): 982-986. https://doi.org/10.1016/j.healthpol.2016.07.006

27 Sibbald, Barbara. "Workplace Violence is Not Part of a Doctor's Job." *Canadian Medical Association Journal* 189.5 E184 (2017). https://doi.org/10.1503/cmaj.170086.

28 Manitoba Wait Times Reduction Task Force. "Wait Times Reduction Task Force: Final Report." *Government of Manitoba,* 21 November 2017, https://www.gov.mb.ca/health/documents/wtrtf.pdf

29 Lunau, Kate and Cathy Gulli. "Canada's Doctor Shortage Worsening." *The Canadian Encyclopedia,* 15 January 2008, https://www.thecanadianencyclopedia.ca/en/article/canadas-doctor-shortage-worsening

In addition to the compelling need to reduce workplace violence for hospital employees, a related KPI that does not appear to be monitored with any consistency is the instance of physical restraint use – particularly when used on children and youth, since the psychological consequences are poorly understood.[30] Given the increasing rates of children and youth seeking mental health supports from EDs, establishing and monitoring consistent metrics would provide valuable insights on effective strategies to improve hospital-related mental health experiences and outcomes for children and youth, in addition to hospital employees.

In order to understand the potential benefits that SafER Space can provide, Myles Ahead reviewed hospital KPIs to identify those that are impacted by the mental health experience in the ED. These relationships are detailed in Table 7.

Table 7: Connecting the Benefits of SafER Space with Applicable Emergency Department (ED) KPIs

Applicable ED KPIs	SafER Space Framework	SafER Space Benefits for ED KPIs
• **Workplace Violence/Safety** • **Patient Wait Time for Provider Initial Assessment (PIA)** • **Patient Satisfaction** • **Employee Lost Time** • **Workforce Satisfaction** • ***Use of Mechanical Restraints****	**Inclusion, Decolonization, Diversity, Equity, Accessibility, and Anti-Violence** **Co-Design**	Using a full-systems lens, integrating inclusion, decolonization, diversity, equity, accessibility, and anti-violence, when engaging with caregivers/families to co-design solutions positively impacts **patient and workforce experience.** Indeed, this approach reveals improvement opportunities that would otherwise not have occurred to mental health clinicians and administrators, resulting in **"inspiring and energizing"** effects on patients and staff to a statistically significant degree.[31]
• **Repeat ED Visit** • ***Complex Patient Outcomes Including Suicide Fatality****	**Community Mental Health Supports**	Wraparound supports with community-based agencies can **reduce** the occurrence and frequency of **repeat visits to EDs** and has the potential to **mitigate** occurrences of post-ED patient discharge suicides.[32] This expands QIPs that provide follow-up care for physical health post-discharge.

30 Nielson, Simon, et al. "Physical restraint of children and adolescents in mental health inpatient services: A systematic review and narrative synthesis." *Journal of Child Health Care* 25.3 (2020): 342-367. https://doi.org/10.1177/1367493520937152

31 Dhalla, Irfan A., and Joshua Tepper. "Improving the quality of health care in Canada." *Canadian Medical Association Journal,* 190.39 (2018): E1162-E1167. https://doi.org/10.1503/cmaj.171045

32 No research was found to indicate that hospitals are tracking post-discharge suicide rates.

Applicable ED KPIs	SafER Space Framework	SafER Space Benefits for ED KPIs
• **Workplace Violence/Safety** • **Patient Wait Time for PIA** • **Patient Satisfaction** • **Employee Satisfaction** • **Employee Lost Time** • ***Use of Mechanical Restraints**** • ***Complex Patient Outcomes Including Suicide Fatality****	 **Peer Support**	Inclusion of caregivers/families and young adult peer support workers to interface with those in need of mental health supports while they are waiting in a busy ED will have a positive impact on ED employees by directly reducing the need for them to interact with people who are experiencing mental health distress. Peer support workers can provide **vital supports** for people struggling with mental health challenges by using recovery-oriented approaches, **listening to concerns and building trust, helping to prepare for and navigate through ED processes,** helping to advocate and encouraging more hopeful outcomes with greater empathy, compassion, and understanding than someone who does not have lived experience, and directly improve patient satisfaction. In addition, peer support workers have been shown to support handover between nurses and doctors, **improving communication.**[33]
• **Workplace Violence/Safety** • **Patient Wait Time for PIA** • **Patient Satisfaction** • **Employee Lost Time** • **Employee Satisfaction** • ***Use of Mechanical Restraints**** • ***Complex Patient Outcomes Including Suicide Fatality****	 **Clinician Support**	Hospitals that include experienced mental health clinicians, as part of their ED employees, show increased safety planning and discharge follow-up practices.[34] Additionally, evidence suggests immediately available mental health clinicians can help stabilize people and situations more quickly and reduce hospital admission frequency.[35]
• **Workplace Violence/Safety** • **Employee Lost Time** • **Patient Satisfaction** • **Employee Satisfaction** • ***Use of Mechanical Restraints**** • ***Complex Patient Outcomes Including Suicide Fatality****	 **Training**	Integrating best Code White **De-escalation practices,** such as Trauma-Informed De-Escalation training (TIDES), OMEGA, as well as preventive training, such as Mental Health First Aid for Adults who Interact With Youth (soon to be renamed), ISBAR, and Patient Behavioural Screening into the compliance training requirements for **all ED employees, including security employees, peer support workers, mental health clinicians, triage nurses, and doctors,** will help mitigate violent incidents. Violent incidents for children and youth in EDs are traumatic for everyone, and ensuring the full team are skilled in de-escalation practices, particularly when **coupled with a calming/therapeutic environment,** has demonstrated a significant reduction in workplace violence incidents.[36]

33 Horevitz, Elizabeth, Kurt C. Organista, and Patricia A. Arean. "Depression treatment uptake in integrated primary care: How a "warm handoff" and other factors affect decision making by Latinos." *Psychiatric Services* 66.8 (2015): 824-830. https://doi.org/10.1176/appi.ps.201400085

34 Wiesel Cullen, Sara, et al. "Impact of around-the-clock mental health staffing on emergency department management of patients who deliberately self-harm." *Psychiatric services* 71.9 (2020): 913-919. https://doi.org/10.1176/appi.ps.201900536

35 Zeller, Scott. "Redefining Acute Behavioural Healthcare: How an Empowered ED Improves Patient Care. White paper." Vituity, https://www.vituity.com/media/2178/redefining_acute_behavioral_healthcare.pdf?utm_source=blog&utm_medium=CTA-widget&utm_campaign=Empath-paper

36 Ibid

Applicable ED KPIs	SafER Space Framework	SafER Space Benefits for ED KPIs
• **Workplace Violence/Safety** • **Patient Satisfaction** • **Workforce Satisfaction** • **Employee Lost Time** • **Repeat ED Visit** • ***Use of Mechanical Restraints**** • ***Complex Patient Outcomes Including Suicide Fatality****	**Triage & Discharge**	Hospitals can be scary places, especially for children and youth already experiencing mental health distress. Having every SafER Space component fully integrated into the ED and triage process presents a step-change in reimagining care within EDs. The evidence presents a compelling case, and a more inclusive and compassionate environment would be beneficial for everyone entering and working in the space.[37] Additionally, in the discharge process, SafER Space will enable the continuity of care that supports sustainably positive outcomes for patients.
• **Workplace Violence/Safety** • **Employee Lost Time** • **Patient Satisfaction** • **Employee Satisfaction** • ***Use of Mechanical Restraints**** • ***Complex Patient Outcomes Including Suicide Fatality****	**Building Design** **Building Finishings**	Introducing therapeutic physical design elements with calming distractions, quiet zones, and access to biophilia can provide co-regulation support, reduce patient fear and stress and to prevent escalation or loss of control and associated workplace violence incidents.[38] [39] [40] [41] [42]

*Italicized KPIs are not typically included in hospital performance scorecards.

37 Ibid

38 Van Horn, Erin Jessamyn. "The Design of Happiness: Redesigning Interior Spaces to Improve User Health and Wellness." *University of Alberta, Master of Design in Industrial Design Thesis,* (2019). https://era.library.ualberta.ca/items/ebef783e-da83-478b-8467-d5cc99709272/view/6c45f964-4673-419e-a149-ad245c2954df/Van%20Horn_Erin_J_201909_MDes.pdf

39 Shultz, Hanna. "Designing for Mental and Behavioral Health Needs – Crisis Care Spaces Within Emergency Departments." *HKS,* 8 September 2020, https://www.hksinc.com/how-we-think/research/designing-for-mental-and-behavioral-health-needs-crisis-care-spaces-within-emergency-departments/

40 Rose, Kirk. "Designing for Better Mental Health in the Emergency Department." *HMC Architects*, 25 March 2020, https://hmcarchitects.com/news/designing-for-better-mental-health-in-the-emergency-department-2020-03-25/

41 Evans, Gary W. "The Built Environment and Mental Health." *Journal of Urban Health* 80.4 (2003): 536-555. https://dx.doi.org/10.1093%2Fjurban%2Fjtg063

42 Liddicoat, Stephanie, Paul Badcock, and Eoin Killackey. "Principles for Designing the Built Environment of Mental Health Services." *The Lancet Psychiatry* 7.10 (2020): 915-920. https://doi.org/10.1016/S2215-0366(20)30038-9

5.0 Transformation Toolkit

5.1 Change Management & Project Management Phases

For successful implementation and sustainment of SafER Space's framework, the transformation toolkit includes recommended change management considerations, methodologies, analyses, plans, and deliverables, based on evidence-based best practices and experiential knowledge from Myles Ahead's team and community partners. To successfully prepare, manage, and reinforce the organizational change, SafER Space's transformation toolkit references the Prosci® 3-Phase Process and the Prosci® ADKAR® Model.[43]

In addition to strong leadership support and change management, project management is also foundational to the successful implementation and sustainment of SafER Space's framework. Although project management is not in scope for the toolkit, Table 8 illustrates an overview of PMBOK Guide's® project phases relative to the Prosci® 3-Phase Process, emphasizing the importance of their intentional and complementary integration.

Table 8: An adapted and Integrated view of Prosci®'s 3-Phase Process[44] and PMBOK® Guide's Project Phases[45]

	Change Management Phases	Project Management Phases
	Prepare for SafER Space	Initiating SafER Space Project
Tandem	Manage SafER Space	Planning
	Reinforce SafER Space	Executing
		Monitoring & Controlling
		Closing SafER Space Project

The integration of change management and project management will vary depending on an ED's unique needs. For optimum results, it is recommended that the project team includes project management and change management practitioners (e.g., change manager, change analyst), among other expertise (e.g., training designer) as needed, to co-create an integrated approach for successful implementation and sustainment of SafER Space's framework.

Successful individual change is at the heart of successful collective change or organizational change. Thus, effective change management requires an understanding and appreciation of how individuals actualize successful changes, including their motivation for doing so. To realize the benefits of an organizational change, Prosci® has defined five elements that an individual needs to journey through to successfully make change happen: Awareness, Desire, Knowledge, Ability, and Reinforcement (ADKAR®), as illustrated in Figure 10.

43 Hiatt, Jeffrey M. "The Prosci® 3-Phase Process." *Prosci*, 2021, https://www.prosci.com/resources/articles/prosci-methodology

44 Hiatt, Jeffrey M. "The PROSCI ADKAR® Model." *Prosci*, 2021, https://www.prosci.com/methodology/adkar

45 Project Management Institute. "A Guide to the Project Management Body of Knowledge (PMBOK Guide), 6th ed.", *Project Management Institute*, 2017.

Complementary to the ADKAR® model for individual change, the Prosci® 3-Phase Process uses structured, yet adaptable, approaches to help co-design and co-facilitate organizational change, as further detailed in the following sections.

Figure 10. Prosci® ADKAR® Model for Individual Change.[46]

5.2 Phase 1: Prepare for SafER Space

The first phase of the Prosci® 3-Phase Process includes activities to prepare for change, including preparation of the project team, and the key deliverable is the Change Management Strategy. This primarily defines the successes, impacts, and approaches to integrate SafER Space's framework within an ED. Based on proven experience and input from community partners, Myles Ahead's team adapted Prosci®'s Phase 1 to include the recommended activities outlined in Figure 11 and the corresponding templates are in Appendices B-K, which provide further detail.

Define Change Management Strategy
PESTLE-SWOT Analysis
Change Impact Assessment
Organizational Readiness Assessment
Stakeholder Analysis
Sponsor Assessment

Define Change Management Strategy
Sponsor & Governance Diagram
Change Agent Network Diagram
RACI Chart
Logic Model
Change Management Strategy

Figure 11. Change Management Phase 1 – Adapted from the Prosci® 3-Phase Process.[47]

46 Hiatt, Jeffrey M. "The PROSCI ADKAR® Model." *Prosci*, 2021, https://www.prosci.com/methodology/adkar

47 Hiatt, Jeffrey M. "The Prosci® 3-Phase Process." *Prosci*, 2021, https://www.prosci.com/resources/articles/prosci-methodology

5.3 Phase 2: Manage SafER Space

The second phase of the Prosci® 3-Phase Process includes activities to manage change. This is primarily when Change Management Plans are developed and implemented to actualize the Change Management Strategy, iteratively adjusting as necessary, for the integration of SafER Space's framework within an ED. Based on proven experience and input from community partners, Myles Ahead's team adapted Prosci®'s Phase 2 to include the recommended activities outlined in Figure 12 and the corresponding templates are in Appendices L-P, which provide further detail.

<table>
<tr><th colspan="2">Develop Change Management Plans</th><th colspan="2">Implement Change Management Plans</th></tr>
<tr><td colspan="4">Communications Plan</td></tr>
<tr><td colspan="4">Sponsor & Governance Plan</td></tr>
<tr><td colspan="2" rowspan="4"></td><td colspan="2">Executive Key Messages</td></tr>
<tr><td colspan="2">People Manager Key Messages</td></tr>
<tr><td colspan="2">All-Employee Key Messages</td></tr>
<tr><td colspan="2">Community Key Messages</td></tr>
<tr><td colspan="4">Change Agent Network Plan</td></tr>
<tr><td colspan="4">Coaching Plan</td></tr>
<tr><td colspan="2" rowspan="2">Training Needs Assessment& Training Plan</td><td rowspan="2">Training Curriculum</td><td>Co-Design Training</td><td>Test Training</td></tr>
<tr><td>Develop Training</td><td>Deliver Training</td></tr>
<tr><td colspan="4">Evaluation, Measurement & Verification Plan</td></tr>
<tr><td colspan="4">Resistance Management Plan</td></tr>
<tr><td colspan="2">Sustainment Plan</td><td colspan="2"></td></tr>
</table>

Figure 12. Change Management Phase 2 – Adapted from the Prosci® 3-Phase Process.[48]

5.4 Phase 3: Reinforce SafER Space

The third phase of the Prosci® 3-Phase Process includes activities to reinforce the organizational change. This is primarily when the Sustainment Plan is implemented, with applicable updates from findings in Phase 2, to successfully sustain the integration of SafER Space's framework within an ED. Based on proven experience and input from community partners, Myles Ahead's team adapted Prosci®'s 3-Phase Process to include the recommended activities outlined in Figure 13.

48 Ibid

Implement Sustainment Plan
Activate Sustainment Roles
Manage Resistance
Maintain Communications
Maintain Change Network
Maintain EM&V

Implement Sustainment Plan
Collect & Analyze Feedback
Identify & Implement Corrective Actions
Identify & Celebrate Successes
Identify & Implement Improvements
Capture, Share & Learn Lessons

Figure 13. Change Management Phase 3 – Adapted from the Prosci® 3-Phase Process.[49]

To summarize, Table 9 shows how plans from Phase 2 and Phase 3 relate to the ADKAR® Model, primarily helping to support an individual's successful journey through change, which ultimately enables the successful integration of SafER Space's framework within an ED.

Table 9: Change Management Plans from Phases 2 & 3 and Primary Influences on ADKAR® Journey (Adapted)[50]

Phase 2 & 3 Plans	A (Awareness)	D (Desire)	K (Knowledge)	A (Ability)	R (Reinforce)
Communications Plan	●				●
Sponsor & Governance Plan	●	●			●
Change Agent Network Plan	●	●	●	●	●
Coaching Plan	●	●	●	●	●
Training Plan			●	●	
EM&V Plan			●	●	●
Resistance Management Plan		●			
Sustainment Plan					●

Lastly, throughout SafER Space's phases of transformation, we recommend a continuous improvement model, such as the Plan, Do, Check, Act,[51] illustrated in Figure 12, to help support the efficiency, quality, and accountability for the implementation and sustainment.

49 Ibid

50 Hiatt, Jeffrey M. "Mapping of Change Management Activities to ADKAR®." *ADKAR®: A Model for Change in Business, Government and Our Community*. Prosci, 2006: 46.

51 Murray, Elizabeth J. "Using Iterative Plan-Do-Study-Act Cycles to Improve Teaching Pedagogy." *Nursing Education Perspectives* 39.6 (2018): 375-377. https://doi.org/10.1097/01.nep.0000000000000265

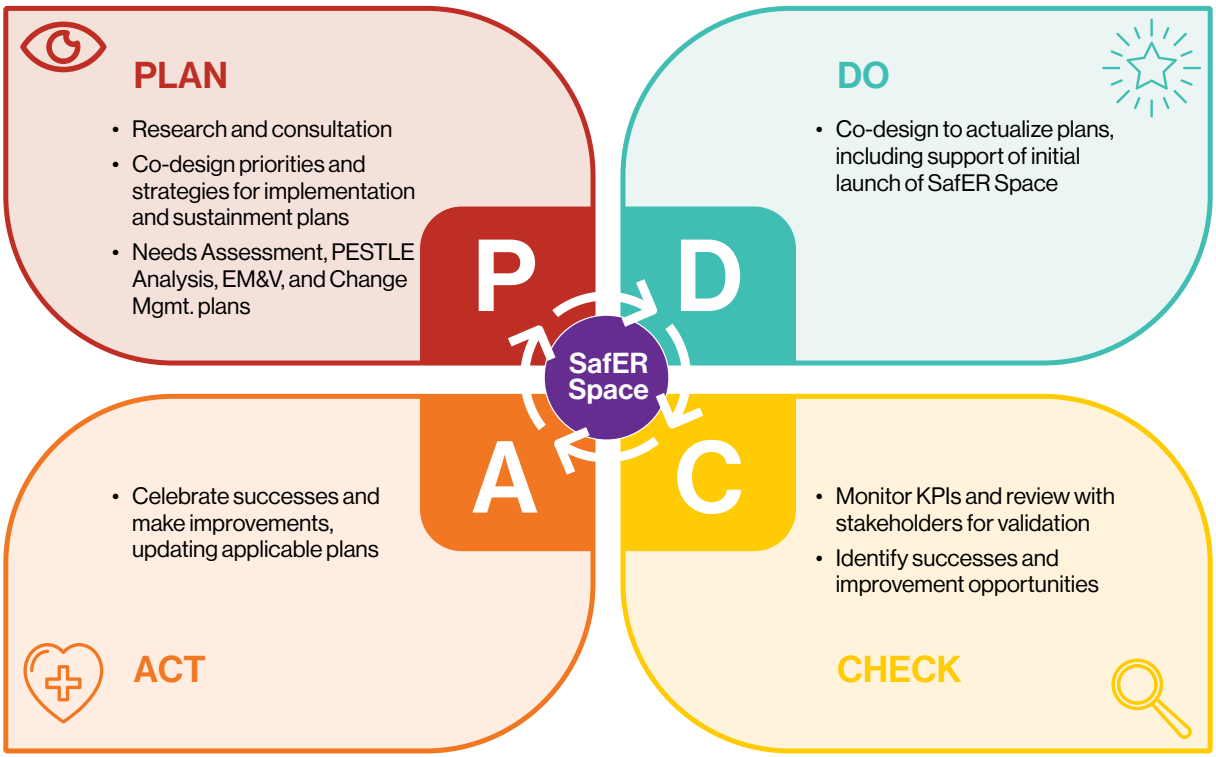


Figure 14. Plan, Do, Check, Act.

6.0 Conclusion

Child and youth suicide mortality rates in Canada are among the highest of all OECD nations.[52] Despite this alarming fact, publicly available mental health services for children and youth are chronically underfunded and oversubscribed, leading to lengthy wait times. EDs frequently appear to be the only option available to help children and youth when they are experiencing mental health challenges. Unfortunately, EDs are neither designed nor resourced to appropriately support mental health needs. To the contrary, EDs can feel like hostile and traumatic environments that amplify pre-existing mental health challenges.

Closely related to building a trauma-informed culture is acknowledging, identifying, and eliminating inequities in the care system for mental health conditions and substance use disorders. For this population, care is often either inaccessible or inadequate to address immediate and long-term needs. However, the challenges for those living with mental health conditions and substance use disorders are often compounded by race, gender, age, sexual orientation, locations, payer status, and other identifying characteristics. It is necessary to view a model of care through an equity lens to fully understand trauma and its effects on individuals and populations. **Exposing and addressing issues of stigma associated with behavioral health issues, unequal treatment, bias, and institutional forms of racism and discrimination are central to improving care.**

Compounding the already challenging conditions, the pandemic has escalated the number of people turning to EDs for mental health support. Incidents of self-harm, suicidality, substance use, and substance overdoses have risen dramatically while hospitals struggle to meet COVID-related treatment demands. In Canada, for example, opioid-related fatalities increased by approximately 88%, from April 2020 to March 2021, for people aged 20-44.[53] With wait times extending to 2.5 years in some regions, and access to urgent intensive treatment taking over three months,[54] it is not surprising that EDs are seeing an increase in people who are seeking mental health support. Indeed, article after article continues to sound the alarm that ED healthcare workers are at their breaking point.

52 "International Suicide Rates of Youth 15 to 24 Years of Age, Canada and Other OECD Countries – the Health of Canada's Children and Youth." *The Health of Canada's Children and Youth, A CICH Profile*, 2012, https://cichprofile.ca/module/1/section/5/page/international-suicide-rates-of-youth-15-to-24-years-of-age-canada-and-other-oecd-countries/.

53 Government of Canada, Statistics Canada. "COVID-19 in Canada: Year-end Update on Social and Economic Impacts." *Government of Canada, Statistics Canada*, 22 Dec. 2021, https://www150.statcan.gc.ca/n1/pub/11-631-x/11-631-x2021003-eng.htm.

54 Moroz, Nicholas, Isabella Moroz, and Monika Slovinec D'Angelo. "Mental Health Services in Canada: Barriers and Cost-Effective Solutions to Increase Access." *Healthcare Management Forum* 33.6 (2020): 282-287. https://doi.org/10.1177/0840470420933911

As Leonard Cohen poignantly noted in his song called Anthem, from the album titled The Future, "There is a crack in everything. That's how the light gets in." In this respect, the pandemic reveals a pivotal course-correction opportunity. SafER Space's framework and transformation toolkit have been developed to provide an evidence-based and scalable solution to support the advancement of EDs to better serve the mental health needs of children and youth in Canada. While SafER Space has been developed specifically to address ED "people," "process," and "place," the scalability of the framework and transformation toolkit extends beyond EDs; it can be used to inform co-design advancement opportunities throughout hospital ecosystems, healthcare clinics, community mental health agencies, and schools.

SafER Space provides a human-centred approach to mental health supports within EDs, and it can also help alleviate the economic burden associated with mental health challenges in Canada, including the workplace culture and KPI risks for hospitals. It is **an approach for hospitals to demonstrate genuine commitment to compassionate care, integrating equity, diversity, and inclusion,** in alignment with their value statements and the rights of patients and caregivers/families.

Despite these alarming statistics, and the strong correlation between mental illness and suicide, only 7% of the healthcare budget in Canada is spent on mental health services.[55] This is an enormous inequity in the resourcing of Canada's healthcare system. Collectively and individually, we need to stop treating mental health as separate from standard health care. Today, the cost and multidimensional burden of children and youth mental health care is inordinately shouldered by caregivers/families. Not only does the SafER Space framework and transformation toolkit provide an opportunity for hospitals to fully practice the values of inclusion, decolonization, diversity, equity, accessibility, and anti-violence, it also helps to tailor EDs to better support the mental health needs of all Canadians.

55 Moroz, Nicholas, Isabella Moroz, and Monika Slovinec D'Angelo. "Mental Health Services in Canada: Barriers and Cost-Effective Solutions to Increase Access." *Healthcare Management Forum* 33.6 (2020): 282-287. https:// doi.org/10.1177/0840470420933911

Acknowledgements

The SafER Space framework and transformation toolkit is a system-level change opportunity developed as part of Myles Ahead's objective to advance mental health practices in support of child and youth mental health. Undertaking this project has been a passion project for us, and we are immensely grateful to the many people who have helped us throughout the research and development process.

Through our research and discussions with mental health industry partners, several subject matter experts were identified who have tangible hands-on experience within the intersection of Emergency Departments and Mental Health. We are grateful for the perspectives, advice, insights, and guidance provided by these subject matter experts, who include the following:

Dr. Mario Cappelli, Senior Clinician Scientist, Knowledge Institute for Child and Youth Mental Health and Addiction. Dr. Cappelli is an expert in the child and youth mental health sphere and works extensively on creating tools that support consistent and effective mental health diagnoses, such as HEADS-ED, a rapid mental health screening tool to assess children and youth who are experiencing a crisis.

Gina Dimitropoulos, PhD, Associate Professor in the Faculty of Social Work at the University of Calgary. Gina studies pediatric EDs and is working on implementing peer support in this space. She is also a Clinical Fellow and Supervisor with the American Association for Marriage and Family Therapy, Certified Family Therapist and Supervisor with the Training Institute for Child and Adolescent Eating Disorders, and Research Lead for the Calgary Eating Disorder Program.

Allison Dunning, National Manager, Peer Support Canada. In Allison's previous Peer Initiative Manager role with Stella's Place, she created customized peer support training content and trained peer workers to support the Emergency Department at Mount Sinai Hospital in Toronto.

Amanda Newton, PhD; Professor, Department of Pediatrics, Faculty of Medicine and Dentistry, University of Alberta. Dr. Newton has expertise in developing and evaluating interventions to improve mental health care delivery and outcomes in children.

Steve Phillips, Founder of The Jordan Legacy, a non-profit organization dedicated to life promotion/suicide prevention in London, England. The Jordan Legacy empowers knowledge mobilization through multiple facets, including conferences such as the Retreats and Safe Spaces to Support Mental Wellbeing. This conference hosted a panel of speakers, including Chukumeka Maxwell from Action to Prevent Suicide CIC and Goodwill Farm (Devon), Ellen O'Donoghue, CEO of James' Place (London and Liverpool), and Debbie Rogers, Founder of Sean's Place CIC (Liverpool), and Leslie Kulperger, Founder of Myles Ahead.

Fran Timmins, Director of Nursing Mental Health Executive Services, St. Vincent's Hospital in Melbourne Australia. Fran has led the implementation of Australia's first holistic and co-designed initiative, the Safe Haven Café, to address the mental health and wellbeing needs of those who would traditionally need a hospital ED.

Dr. Scott Zeller, Vice President of Acute Psychiatry at Vituity and Assistant Clinical Professor of Psychiatry at the University of California, Riverside. Dr. Zeller led the development of the EmPath units in the USA, a best-practice approach to support acute mental health patients arriving in the ED.

In addition, we wish to thank the Myles Ahead Board of Directors for their governance, oversight, and guidance throughout the research and development process. Board members include the following:

Edward Kulperger, Myles Ahead Board Chair, Senior Vice President, Geotab, and on the Board of Directors at BeWhere Inc. (BEW:TSX-V). Edward is dedicated to making a difference in memory of his nephew, Myles. Edward translates his wealth of innovative business development strategies and organizational governance expertise in support of Myles Ahead.

Stacey Espinet, PhD, Myles Ahead Board Co-Chair, Education Manager at CADDRA – Canadian ADHD Resource Alliance. Stacey has over 15 years of experience conducting research and large-scale program evaluations in the fields of child development and mental health. She holds a Doctor of Philosophy in Developmental Psychology from the University of Toronto, focused on facilitating the early emergence of executive-function skills that underlies mental health.

Anseh Dibaji, MSW, Myles Ahead Finance Committee Chair, Lead Social Worker, Taddle Creek Family Health Team. Anseh is a clinical social worker with an MSW from the University of Toronto and worked in the public children's mental health sector for seven years prior to focusing on youth and adult mental health treatment in a primary care setting.

Bella Karsh, MA, Myles Ahead Board Secretary, Principal, William G. Miller Public School, Toronto District School Board (TDSB). Bella holds a Master of Arts in Applied Psychology and Human Development from the Ontario Institute for Studies in Education (OISE) at the University of Toronto. Bella is a passionate advocate for children with special needs and brings a wealth of classroom and school administration experience spanning over 17 years.

Michael Singleton, Myles Ahead Board Treasurer, Executive Director of Sustainable Buildings Canada. Michael provides governance and strategic oversight required to run a Canadian non-profit, leveraging his background as an environmental economist with 20 years of experience operating a non-profit organization.

Dr. Dina Lafoyiannis, Myles Ahead Board Director, Registered Clinical Psychologist, Dr. Lafoyiannis & Associates. Dina brings over 10 years experience as a clinical psychologist, including seven years with SickKids Centre for Community Mental Health. Dina is also an adjunct clinical supervisor at OISE and at York University.

And finally, we are indebted to the ongoing advisory guidance that Myles' Aunt Shelley provided:

Shelley Kulperger, PhD, Principal, Suicide Prevention in Health Services, Queensland Health, Australia. Shelley shared real-time insights into the co-design, creation, and implementation process she led for the Crisis Support Space in North Brisbane Hospital. Shelley is part of a statewide collaborative network of Crisis Support Service implementers in diverse ED settings, urban and regional (i.e., Mackay, Brisbane, Gold Coast, Ipswich, Harvey Bay, Townsville, and Toowoomba).

Bibliography

Affleck, William, et al. “Suicide Amongst the Inuit of Nunavut: An Exploration of Life Trajectories.” *International Journal of Environmental Research and Public Health* 17.6 (2020): 1812. https://doi.org/10.3390/ijerph17061812

Agostino, Holly, et al. “Trends in the Incidence of New-Onset Anorexia Nervosa and Atypical Anorexia Nervosa Among Youth During the COVID-19 Pandemic in Canada.” *JAMA Network Open* 4.12 (2021): e2137395-e2137395. https://doi.org/10.1001/jamanetworkopen.2021.37395

Backman, Chantal, Saskia Vanderloo, and Alan John Forster. “Measuring and Improving Quality in University Hospitals in Canada: The Collaborative for Excellence in Healthcare Quality.” *Health Policy* 120.9 (2016): 982-986. https://doi.org/10.1016/j.healthpol.2016.07.006

Borckardt, Jeffrey J., et al. “Systematic Investigation of Initiatives to Reduce Seclusion and Restraint in a State Psychiatric Hospital.” *Psychiatric Services* 62.5 (2011): 477-483. https://doi.org/10.1176/ps.62.5.pss6205_0477

Brown, Denise. “EmPATH: Stopping the Dehumanization of Behavioural Health Patients in Emergency Departments.” *STAT,* 2 July 2019, https://www.statnews.com/2019/07/02/empath- model-behavioral-health-emergency-departments

Bruns, Eric J., et al. “Ten Principles of the Wraparound Process.” *Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children’s Mental Health, Portland State University*, (2004). https://www.researchgate.net/publication/265616599_Ten_Principles_of_the_Wraparound_Process.

Butler, A., et al. “Towards Quality Mental Health Services in Canada: A Comparison of Performance Indicators Across 5 Provinces.” *Vancouver BC: Centre for Applied Research in Mental Health & Addiction (CARMHA)*, (2017): 1–134. http://www.sfu.ca/carmha/publications/prov_indic_2017.html.

Canadian Mental Health Association, Ontario. “Addressing Emergency Department Wait Times and Enhancing Access to Community Mental Health & Addictions Services and Supports.” *Canadian Mental Health Association, Ontario*, July 2008, https://ontario.cmha.ca/documents/addressing-emergency-%20department-wait-times-and-enhancing-access-to-community-mental-health-and-%20addictions-services-and-supports

Campbell, Leslie Anne, et al. “Opening the Door: Inviting Youth and Parent Perspectives on Youth Mental Health Emergency Department Use.” *Research Involvement and Engagement* 6.26 (2020): 1-8. https://doi.org/10.1186/s40900-020-00204-7

Champagne, Tina, and Nan Stromberg. “Sensory Approaches in Inpatient Psychiatric Settings: Innovative Alternatives to Seclusion and Restraint.” *Journal of Psychosocial Nursing and Mental Health Services* 42.9 (2004): 34-44. https://doi.org/10.3928/02793695-20040901-06

Children’s Healthcare Canada. “Expanding urgent health supports for Canada’s children and youth”, *Children’s Health Canada*, 19 April 2021, static1.squarespace.com/static/5bd8a55e4eddecb150a2acdb/t/607f615f39c5cd3dffa401b1/1618960736458/Expanding+urgent+health+supports+for+Canada.pdf

Creasey, Tim. “5 Tips for Better Communication around Change.” *Prosci*, https://blog.prosci.com/5-tips-for-better-communication-around-change.

Creasey, Tim. “Creating Successful Coaching with the ADKAR Model.” *Prosci*, https://blog.prosci.com/creating-successful-coaching-with-the-adkar-model.

Cyr, Céline, et al. “Making the Case for Peer Support.” *Mental Health Commission of Canada*, 29 July 2016, https://mentalhealthcommission.ca/resource/making-the-case-for-peer-support

Dhalla, Irfan A., and Joshua Tepper. “Improving the Quality of Health Care in Canada.” *Canadian Medical Association Journal* 190.39 (2018): E1162-E1167. https://doi.org/10.1503/cmaj.171045

Evans, Gary W. “The Built Environment and Mental Health.” *Journal of Urban Health* 80.4 (2003): 536-555. https://dx.doi.org/10.1093%2Fjurban%2Fjtg063

Goodman, Saul. “The Emergency Department Diversion Program at North York General Hospital: An Integrated Response to Mental Health Clients in Crisis.” Poster Presentation: Celebrating Innovations in Health Care Expo. Toronto, 2008.

Government of Canada; Indigenous Services Canada. “Suicide Prevention in Indigenous Communities.” *Government of Canada; Indigenous Services Canada*, 17 Jan. 2022, https://www.sac-isc.gc.ca/eng/1576089685593/1576089741803#sec1

Government of Canada, Statistics Canada. “COVID-19 in Canada: Year-end Update on Social and Economic Impacts.” *Government of Canada, Statistics Canada*, 22 Dec. 2021, https://www150.statcan.gc.ca/n1/pub/11-631-x/11-631-x2021003-eng.htm.

Hiatt, Jeffery M. “Desire - the PROSCI Adkar Model.” *Prosci*, https://www.prosci.com/resources/articles/adkar-model-desire

Hiatt, Jeffrey M. “Mapping of Change Management Activities to ADKAR®.” *ADKAR®: A Model for Change in Business, Government and Our Community*. Prosci, 2006: 46.

Hiatt, Jeffery M. “The Global Leader in Change Management Solutions.” *Prosci*, https://www.prosci.com/

Hiatt, Jeffrey M. “The Prosci® 3-Phase Process.” *Prosci*, 2021, https://www.prosci.com/resources/articles/prosci-methodology

Hiatt, Jeffrey M. “The PROSCI ADKAR® Model.” *Prosci*, 2021, https://www.prosci.com/methodology/adkar

Hiatt, Jefferey M. “Reinforcement - the Prosci® ADKAR Model.” *Prosci*, https://www.prosci.com/resources/articles

Horevitz, Elizabeth, Kurt C. Organista, and Patricia A. Arean. “Depression Treatment Uptake in integrated Primary Care: How a “Warm Handoff” and Other Factors Affect Decision Making by Latinos.” *Psychiatric Services* 66.8 (2015): 824-830. https://doi.org/10.1176/appi.ps.201400085

“International Suicide Rates of Youth 15 to 24 Years of Age, Canada and Other OECD Countries – the Health of Canada’s Children and Youth.” *The Health of Canada’s Children and Youth, A CICH Profile*, 2012, https://cichprofile.ca/module/1/section/5/page/international-suicide-rates-of-youth-15-to-24-years-of-age-canada-and-other-oecd-countries/.

“Interprofessional Communication in Nursing: Resources to Facilitate Interprofessional Communication.” *Introduction to Communication in Nursing*, edited by Jennifer Lapum, Oona St-Amant, Michelle Hughes and Joy Garmaise-Yee, X University Pressbooks. https://pressbooks.library.ryerson.ca/communicationnursing/chapter/resources-to-facilitate-interprofessional-communication/

Jones, Elizabeth, Clare Lucey, and Liz Wadland. “Triage: A Waiting List Initiative in a Child Mental Health Service.” *Psychiatric Bulletin* 24.2 (2000): 57-59. https://doi.org/10.1192/pb.24.2.57

Kaur, Mandeep, and Robert H. Melville Jr. “Emergency Department Peer Support Specialist Program.” *Psychiatric Services* 72.2 (2021): 230-230. https://doi.org/10.1176/appi.ps.72102

Kendal, Sandi. “From “Emergency Couch” to Emergency Care: Providing Health Care Options to People in Mental Health Crisis.” *Network* 25.2 (2009): 9-13. https://ontario.cmha.ca/wp-content/files/2013/04/fall_2009.pdf.

Lerwick, Julie L. “Minimizing Pediatric Healthcare-Induced Anxiety and Trauma.” *World journal of Clinical Pediatrics* 5.2 (2016): 143-150. https://doi.org/10.5409/wjcp.v5.i2.143.

Liddicoat, Stephanie, Paul Badcock, and Eoin Killackey. “Principles for Designing the Built Environment of Mental Health Services.” *The Lancet Psychiatry* 7.10 (2020): 915-920. https://doi.org/10.1016/S2215-0366(20)30038-9

Lyon, Aaron R., et al. “Designing the Future of Children’s Mental Health Services.” *Administration and Policy in Mental Health and Mental Health Services Research* 47 (2020): 735-751. https://doi.org/10.1007/s10488-020-01038-x

Manitoba Wait Times Reduction Task Force. “Wait Times Reduction Task Force: Final Report.” *Government of Manitoba,* 21 November 2017, https://www.gov.mb.ca/health/documents/wtrtf.pdf

McLoughlin, Aoibheann B., Madelyn S. Gould, and Kevin M. Malone. "Global Trends in Teenage Suicide: 2003–2014." *QJM: An International Journal of Medicine* 108.10 (2015): 765-780. https://doi.org/10.1093/qjmed/hcv026

"Mental Health First Aid Canada: Adults who Interact with Youth." *Mental Health Commission of Canada*, https://www.mhfa.ca/en/course-type/adults-who-interact-youth

Moroz, Nicholas, Isabella Moroz, and Monika Slovinec D'Angelo. "Mental Health Services in Canada: Barriers and Cost-Effective Solutions to Increase Access." *Healthcare Management Forum* 33.6 (2020): 282-287. https://doi.org/10.1177/0840470420933911

Murray, Elizabeth J. "Using Iterative Plan-Do-Study-Act Cycles to Improve Teaching Pedagogy." *Nursing Education Perspectives* 39.6 (2018): 375-377. https://doi.org/10.1097/01.nep.0000000000000265

Nanda, Upali, et al. "Effect of Visual Art on Patient Anxiety and Agitation in a Mental Health Facility and Implications for the Business Case." *Journal of Psychiatric and Mental Health Nursing* 18.5 (2011): 386-393. https://doi.org/10.1111/j.1365-2850.2010.01682.x

Nielson, Simon, et al. "Physical Restraint of Children and Adolescents in Mental Health Inpatient Services: A Systematic Review and Narrative Synthesis." *Journal of Child Health Care* 25.3 (2020): 342-367. https://doi.org/10.1177/1367493520937152

Nielsen, Stine L., et al. "How Do Patients Actually Experience and Use Art in Hospitals? The Significance of Interaction: A User-Oriented Experimental Case Study." *International Journal of Qualitative Studies on Health and Well-Being* 12.1 (2017): 1267343. https://doi.org/10.1080/17482631.2016.1267343

Novak, Theresa, et al. "Pilot Study of a Sensory Room in an Acute Inpatient Psychiatric Unit." *Australasian Psychiatry* 20.5 (2012): 401-406. https://doi.org/10.1177/1039856212459585

"Peer Support Program Supports Youth Through Mental Health and Addictions Crises in the ED." *Family and Community Medicine, University of Toronto*, 4 February 2021, https://dfcm.utoronto.ca/news/peer-support-program-supports-youth-through-mental-health-and-addictions-crises-ed

Project Management Institute. "A Guide to the Project Management Body of Knowledge (PMBOK Guide), 6th ed.", *Project Management Institute*, 2017.

"Raci Charts - How-to Guide and Templates." *RACI Charts*, https://racichart.org/.

Rose, Kirk. "Designing for Better Mental Health in the Emergency Department." *HMC Architects*, 25 March 2020, https://hmcarchitects.com/news/designing-for-better-mental-health-in-the-emergency-department-2020-03-25/

Shultz, Hanna. "Designing for Mental and Behavioral Health Needs – Crisis Care Spaces Within Emergency Departments." *HKS,* 8 September 2020, https://www.hksinc.com/how-we-think/research/designing-for-mental-and-behavioral-health-needs-crisis-care-spaces-within-emergency-departments/

Sibbald, Barbara. “Workplace Violence is Not Part of a Doctor’s Job.” *Canadian Medical Association Journal* 189.5 E184 (2017). https://doi.org/10.1503/cmaj.170086.

Sirkin, Harold L., Perry Keenan, and Alan Jackson. “The Hard Side of Change Management.” *The Harvard Business Review*, October 2005, https://hbr.org/2005/10/the-hard-side-of-change-management

Stevenson, Jean. “The Circle of Healing.” *Native Social Work Journal* 2.1 (1999): 8-21. https://iaac-aeic.gc.ca/050/documents/p63928/92023E.pdf.

Stewart, Moira A. “Effective Physician-Patient Communication and Health Outcomes: A Review.”*Canadian Medical Association Journal* 152.9 (1995): 1423. PMC1337906

“The Empathy Toy®” *Twenty One Toys*, https://twentyonetoys.com/pages/empathy-toy

Thielking, Megan. “‘Traumatic as Hell’: Patients Describe What It’s like to Be Restrained in an ER.” *STAT*, 24 Jan. 2020, www.statnews.com/2020/01/24/patients-restrained-in-the-er/.

Ulrich, Roger S., et al. “Psychiatric Ward Design Can Reduce Aggressive Behavior.” *Journal of Environmental Psychology* 57 (2018): 53-66. https://doi.org/10.1016/j.jenvp.2018.05.002

Van Horn, Erin Jessamyn. “The Design of Happiness: Redesigning Interior Spaces to Improve User Health and Wellness.” *University of Alberta, Master of Design in Industrial Design*

Thesis, (2019). https://era.library.ualberta.ca/items/ebef783e-da83-478b-8467-d5cc99709272/view/6c45f964-4673-419e-a149-ad245c2954df/Van%20Horn_Erin_J_201909_MDes.pdf

Wiesel Cullen, Sara, et al. “Impact of Around-The-Clock Mental Health Staffing on Emergency Department Management of Patients Who Deliberately Self-Harm.” *Psychiatric services* 71.9 (2020): 913-919. https://doi.org/10.1176/appi.ps.201900536

Young, Nicholas D., et al. “Warm handoff, or Cold Shoulder? An Analysis of Handoffs for Primary Care Behavioral Health Consultation on Patient Engagement and Systems Utilization.” *Clinical Practice in Pediatric Psychology* 8.3 (2020): 241-246. https://doi.org/10.1037/cpp0000360.

Zeller, Scott. “EmPATH Units as a Solution for ED Psychiatric Patient Boarding.” *Psychiatry Advisor*, 2018, www.psychiatryadvisor.com/home/practice-management/empath-units-as-a-solution-for-ed-psychiatric-patient-boarding/.

Zeller, Scott. “Redefining Acute Behavioural Healthcare: How an Empowered ED Improves Patient Care. White paper.” Vituity, https://www.vituity.com/media/2178/redefining_acute_behavioral_healthcare.pdf?utm_source=blog&utm_medium=CTA-widget&utm_campaign=Empath-paper

Appendices: Transformation Toolkit Templates

Appendix A: Business Case Template

One of the precursors to a successful project is a strong business case, which helps to clearly establish the rationale for approval of the project to proceed. The business case includes an evaluation of associated benefits, costs, and risks, among other content, to help provide decision-makers with the necessary information to determine whether to proceed with the project. An approved business case informs the project charter and helps to pave the way for a successful initiation and implementation of the project.

Thus, it is highly recommended that hospitals complete a formal business case document, unique to their organization, so that the compelling case for SafER Space is clearly outlined and can be readily communicated to various stakeholders, including executive leadership and the project sponsor who approves the project to proceed. The business case is a record of the options and recommendations, including the rationale, ultimately to support the decision to implement and sustain SafER Space. While there are many formats that can be used to create a business case document, the outline below is one example that can be edited as applicable.

Executive Summary

- given this section is an overview of the entire business case document, including an outline of the project's purpose, objectives, and outcomes, it is often helpful to write it at the end
- include key quantitative (e.g., relevant statistics, estimated timeline and investment, key project-specific performance indicators targets, and other benefits) and qualitative (e.g., strategic alignment, employee satisfaction, improved patient experience) reasons; recommended next steps, including a clear statement of what a decision-maker(s) is/are asked to approve

1.0 Purpose

- connects to "why" a hospital is initiating a project to implement and sustain SafER Space

1.1 Scope

- an overview of who and what (e.g., people, processes, systems, technologies, and building operations) will be impacted by implementing SafER Space

1.2 Background

- details of any prior changes, actions, and/or activities that are related to the business case

1.3 Current State

- an evaluation of a hospital's current state (e.g., people, processes, systems, technologies, and

building operations) focused on elements that will be changed as a result of implementing SafER Space
- include a "problem statement" or "identified gaps" to help clarify the need for SafER Space

1.4 Future State

- an evaluation of a hospital's future state (e.g., people, processes, systems, technologies, and building operations) focused on specific SafER Space changes that will help to advance child and youth mental health within the hospital's ED
- include a "solution statement" or "vision statement" to help clarify how SafER Space addresses the problem and/or gaps

1.5 Objectives

- goals of the project to achieve desired outcomes, including benefits
- include existing and new key performance indicators that will be monitored in relation to SafER Space

1.6 Outcomes

- outlines the project's desired outcomes, including benefits
- include existing and new key performance indicator targets that will demonstrate SafER Space outcomes

2.0 Strategic Alignment

- strategic context helps to illustrate the ways that SafER Space is aligned with the hospital's priorities, which connects to the compelling case for change

3.0 Benefit Analysis

- details of the organizational benefits of SafER Space, including financial and non-financial (e.g., brand trust, reduced workplace insurance claims, reduced employee lost-time work)

Table 10: Project Benefits

Benefit Name	Description	Classification
What is the name of the benefit (e.g., Reduced ED Visits)?	Describe the benefit (e.g., SafER Space is a holistic systems approach that will reduce repeat visits to ED).	What is the type of benefit (e.g., financial, non-financial)?

4.0 Risk Analysis

- assess associated risks to initiate the project or not, in addition to how risks will be mitigated during the project
- can inform a risk register for the project and related activities
- describe the degree of difficulty to define and/or understand the “problem statement” and proposed SafER Space solution
- clarify whether the “problem statement” is straightforward or complex and why, in addition to whether the problem is widely known
- estimate whether SafER Space will be largely accepted or resisted by stakeholders

Table 11: Project Risks

Risk	Likelihood	Consequence	Mitigation	Accountability

5.0 Evaluation, Measurement & Verification

- once the project is completed, this section describes why evaluation, measurement, and verification (EMV) is necessary, who will do it, and when it will be completed; the EMV Plan, in Appendix P, may be a useful reference

6.0 Feasibility

- outline how quality, funding, and schedule will be balanced to practically realize the benefits of SafER Space

6.1 Funding

- helps to align the quantitative and qualitative benefits for initiating the project to implement and sustain SaFER Space, including comparisons with other options

Table 12: Estimation of Funding Requirements (based on budget cycles)

Funding Item	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
Yearly Totals	Sum of above	Sum of above	Sum of above	Sum of above	Sum of above	Sum of above

6.2 Schedule

- provide a timeline in a format (e.g., Gantt Chart) that includes key milestones

6.3 Resources

- Estimate number of people, including roles, availabilities, and capabilities, necessary to initiate and complete the project; identify if any skill sets and/or specialist resources (e.g., project manager, change practitioners) are required

Table 13: Estimation of Requirements for Resources

Financial Year	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Number of Existing Employees						
Number of Additional Internal Employees						
Number of Additional External Employees						
Other Requirements						

6.4 Governance & Accountability

- include names and titles of those who are accountable and responsible for the project; also include names in Approval & Endorsement (Section 10.0) ensuring they are aware of their roles, responsibilities, and accountability
- identify a project sponsor to be the accountable decision-maker, who is supported by a steering committee, or similar, including relevant expertise
- Ensure everyone on this list is aware of their roles and responsibilities and are included in Approval & Endorsement (Section 10.0)

Dependencies

- describe any other projects that will impact the initiation of this project (e.g., funding, schedule, resources)

6.5 Impacts

- identify additional possible impacts, including the type of impact and who will be impacted (i.e., internal and external)
- include impacts during the project's lifecycle and ongoing impacts due to the project's implementation of SafER Space

7.0 Related Activities & Documents

- list any activities and documents that complement or support the business case
- initial change management activities, such as the Change Impact Assessment (Appendix C) and Organizational Readiness Assessment (Appendix D), could be helpful to include with the business case, depending on the hospital's organizational needs at this stage

8.0 Options Analysis

- provide an analysis of options to help the project sponsor make an informed decision

9.0 Recommendation

- summarize the reasons why the project should be initiated and identify the impacts of not initiating the project to implement and sustain SafER Space
- provide insights and recommend SafER Space, which offers the maximum positive benefits with the lowest funding and risk
- outline how funding will be effectively managed and allocated to achieve the results

10.0 Approval & Endorsement

☐ Progress to Initiation Phase of Project
☐ Revise and Resubmit Business Case
☐ Do Not Proceed with Project
Comments:

Project Manager			
Name			
Position			
Signature		Date	

Project Sponsor			
Name			
Position			
Signature		Date	

11.0 Contact

- include contact information for questions or comments regarding the business case document, such as the following:

Contact:	Contact Name here
Title:	Contact Title here
Phone:	Contact Phone Number here
Email:	Contact Email here

Appendices

- include supporting documents, as applicable, such as:
  - budget
  - evaluation plan
  - organizational dependencies
  - organization chart

Appendix B: PESTLE-SWOT Analysis

To help prepare for the implementation of SafER Space, as co-designed with stakeholders (Appendix E), a PESTLE[56]-SWOT[57] analysis can be a helpful tool to obtain an initial macro understanding of the strengths, weaknesses, opportunities, and threats within the context of political, economic, social, technological, legal, and environmental influences that the hospital might consider. Table 14 includes questions as prompts to help complete the analysis for a particular implementation and sustainment of SafER Space.

Table 14: PESTLE-SWOT Analysis with Question Prompts

	Political	Economic	Social	Technological	Legal	Environmental
Strengths	Which internal hospital departments align with the SafER Space mission? Which government bodies emphasize the need to prioritize mental health?	Are there budgetary surpluses that can be leveraged? Are there existing economic case studies to support the business case for SafER Space?	Is social awareness of the need for SafER Space at a tipping point, providing an additional catalyst for change? Has the pandemic impacted the social desire for change?	Can existing technologies be expanded to integrate with SafER Space? Can SafER Space performance data be tracked within the existing system? What technology interface systems are necessary (e.g., patient data, SafER Space integration, information exchange between the hospital and community mental health support agencies)?	Are processes in place to support regulatory and legal compliance? Is there a legal agreement in place between the hospital and the community mental health support agencies to support the continuity of care?	Are we in an accessible location? Is the environment stable (e.g., low likelihood of severe environmental incident impacting the hospital or our community)? Will inclusion of SafER Space design elements improve indoor air quality and comfort?
			Does internal key stakeholder experience support the need?			

56 Political, Economic, Social, Technological, Legal, and Environmental

57 Strengths, Weaknesses, Opportunities, and Threats

	Political	Economic	Social	Technological	Legal	Environmental
Weaknesses	Are there internal policy trends and priorities that present a barrier to adopting SafER Space? Which external political policy trends are a barrier to integrating mental health care within the primary healthcare system?	Have increased demands for emergency care created economic challenges for the hospital?	Does mental health stigma exist with hospital stakeholders and/or within hospital departments?	Do all departments use technology systems and requirements consistently?	Have compliance weaknesses been identified through internal audits and/ or by patient complaints?	Are there current challenges to sustain indoor air quality and comfort considering adverse external environmental changes?
Opportunities	Are there hospital stakeholders, departments, and/or policies in support of SafER Space? Will improved mental health of children and youth in Canada be considered a noteworthy political accomplishment?	Are KPIs (that intersect with patient mental health) costing the hospital money (e.g., lost time work, workplace insurance claims)?	Would the internal hospital culture benefit from implementing and sustaining a SafER Space? Is there a general shift in attitude towards implementing meaningful change to support mental health?	Are there existing technology solutions that can be leveraged to support the integration of SafER Space processes? Are there innovative technologies that can showcase the hospital's commitment to mental health?	Are processes in place to help ensure the hospital is prepared for changes to regulatory and legal compliance requirements?	Can the SafER Space initiative align with energy and carbon sustainability goals? Can communities adversely impacted by environmental conditions seek refuge within the hospital common areas?
Threats	Which hospital department priorities are in direct conflict with the SafER Space initiative? Will external political change impact hospital support for SafER Space?	Are there hospital budgetary priorities in conflict with implementation and sustainment of SafER Space?	Are there members of the community who do not access ED services due to extenuating perceptions (e.g., cultural or experiential distrust of hospitals) who, as a result of SafER Space, may present additional stress on the ED?	Are hospital technical controls able to withstand cyber security threats to IT, electrical, and HVAC systems?	Are other jurisdictions being monitored for regulatory and legal changes to identify and proactively implement potential future compliance changes? Could adverse patient mental health outcomes present a future legal challenge?	Will increasing incidents of adverse environmental episodes (e.g., heat waves, localized flooding, forest fires, major snowstorms) increase the need for mental health supports for the community?

Appendix C: Change Impact Assessment

There are several methods to assess the impact of an organizational change, including the **impact for people, processes, places, and technologies**. To illustrate an example of what could be used to assess the impact of integrating SafER Space within a hospital's Emergency Department and beyond, the template below includes a list of questions. It is recommended to conduct interviews with the project sponsor(s) to obtain their answers, which will **help to develop a successful Change Management Strategy (Appendix K) and related activities to successfully implement and sustain SafER Space.**

1. What benefits and/or improvements do you expect for the hospital once SafER Space is implemented? Please clarify your vision of what future-state looks like compared to current-state.

2. Are there any **other projects and/or priorities** that will, or might, impact the implementation of SafER Space? If so, what are they and what impact(s) do you expect?

3. How many **employees** will be impacted by the implementation of SafER Space, including specific divisions, teams, and roles, and what are the impact(s)? Who will be impacted the most by the implementation of SafER Space?

4. How will the implementation of SafER Space impact the hospital's **processes?**

5. How will the implementation of SafER Space impact the hospital's **building and finishings?**

6. How will the implementation of SafER Space impact the hospital's **technologies?**

Appendix D: Organizational Readiness Assessment

There are several methods to assess an organization's readiness for change. To illustrate an example of what could be used to assess a hospital's readiness to implement and sustain SafER Space within its Emergency Department and beyond, the template below includes a list of questions. It is recommended to conduct interviews with the project sponsor(s) to obtain their answers, which will **help to develop a successful Change Management Strategy (Appendix K) and related activities to successfully implement and sustain SafER Space.**

1. What do you think are the **key success factors** for SafER Space?

2. What are the **key challenges** related to the implementation of SafER Space?

3. How supportive is **your team** regarding the implementation of SafER Space? Do you foresee any **resistance and/or champions** of the implementation?

4. Beyond your team, how supportive do you think **managers/supervisors** will be, regarding the implementation of SafER Space? Do you foresee any **resistance and/or champions** of the implementation?

5. Beyond your team and **managers/supervisors,** how supportive do you think **employees** will be throughout the hospital's organization, regarding the implementation of SafER Space? Do you foresee any **resistors and/or champions** of the implementation?

Appendix E: Stakeholder Analysis

Table 15 is provided as a template of what could be used to complete a stakeholder analysis for the implementation and sustainment of SafER Space within a hospital's ED and beyond. Depending on the hospital's unique needs, the template can be expanded using a spreadsheet to include more details and iteratively updated as more information becomes available.

Table 15: Stakeholder Analysis

Stakeholder Name or Group	Impact (H, M, L)	Influence (H, M, L)	Support (H, M, L)	Key Success Criteria	Key Challenges &/ or Concerns	Change Management Approach &/ or Activities

The stakeholder analysis is helpful throughout the project, particularly to **identify the varying support or Desire (D) for change**[58] **and what can be done to help mitigate any resistance**. Also, the stakeholder analysis exercise is helpful to identify sponsors (Appendices F-H).

To complete the stakeholder analysis, the **recommended considerations for stakeholders** include the following:

- families, children, and youth with lived experience
- hospital executives
- ED leadership
- ED doctors
- triage nurses
- triage intake coordinators
- registered nurses, registered practical nurses / licensed practical nurses, registered psychiatric nurses
- technicians
- psychiatrists
- psychologists
- mental health clinicians
- occupational therapists
- peer supporters
- community mental health supports
- security employees
- union representatives

58 Hiatt, Jeffrey M. "The Prosci ADKAR® Model." *Prosci*, 2021, https://www.prosci.com/resources/articles/adkar-model-desire.

Regarding the co-design governance for SafER Space, further considerations for stakeholders include the following:

- How will EDs recruit people with lived/living experience to be involved in the development of SafER Space (i.e., co-design participants), locally, and as part of your governance?
- What is the hospital's policy for remuneration of co-design participants' to implement a local SafER Space initiative?
- How will hospitals help to ensure young people can authentically participate in the co-design of SafER Space?
- How will EDs ensure co-design participants are supported safely, prepared to participate and have a voice at the table, and are recognized for their partnership and contribution?
- What other activities can EDs design to help ensure input from a range of community partners, including a diversity of people who have direct lived/living experience with the ED?
- What access to employee counselling services will you provide?
- What will be the format for co-design meeting preparation and debriefing with co-design participants?

Appendix F: Sponsor Assessment

For successful change, Prosci®'s research shows that an **executive sponsor, or primary sponsor, must fulfil the ABCs of sponsorship:** Prosci®'s defines these ABCs as the following[59]:

- **A**ctively and visibly participate throughout the project
- **B**uild a coalition of sponsorship with other leaders
- **C**ommunicate support and promote the change to impacted groups

The **primary sponsor is responsible for the project's success, budget approvals, allocation of resources, and approval of project goals, objectives, and change management strategy** to implement and sustain SafER Space. Depending on a hospital's unique requirements, the **primary sponsor builds a coalition of sponsorship with other senior leaders, or secondary sponsors, to help advance the change.** Secondary sponsors are accountable for a department or area that is impacted by the change, but they are not primarily accountable for the project's success. The **next level of sponsorship support includes people managers who help to deliver key messages for the change within the impacted groups** that they manage.

In addition, it may be helpful to have the **sponsorship support of change agents who act as a bridge between all the sponsors and stakeholders who are impacted by the change.** Change agents are influencers who help to inspire individuals along the ADKAR®[60] change journey. Also, change agents collaborate closely with the change practitioner, given this resource is allocated to the project (recommended).

Given there are varying degrees of change management awareness and capabilities, some sponsors may require training or coaching to develop their sponsorship skills. **To help assess a person's readiness for a sponsorship role, it is helpful to conduct a sponsor assessment,** such as Table 16. This information helps to determine what training or coaching is necessary; in addition, it helps to build the Sponsor & Governance Diagram (Appendix G) and the Change Agent Network Diagram (Appendix H).

Table 16: Sponsor Assessment

Sponsor Name	Sponsor Role (primary, secondary, people manager, change agent)	Change Management Skills (H, M, L)	Change Support (H, M, L)	Training Required? (Y/N)	Coaching Required? (Y/N)	Sponsorship Approach &/ or Activities

59 Hiatt, Jeffery M. "The Global Leader in Change Management Solutions." *Prosci*, https://www.prosci.com/

60 Hiatt, Jeffrey M. "The PROSCI ADKAR® Model." *Prosci*, 2021, https://www.prosci.com/methodology/adkar

Appendix G: Sponsor & Governance Diagram

The executive sponsor or primary sponsor is the governance link between the hospital's executive team who determines the strategy for SafER Space and the project team, including change management practitioners, who implement the strategy and help to ensure its sustainment.

Depending on the hospital's unique needs, it may be helpful to have additional governance structures, such as a steering committee and a working group. Based on inputs from the Stakeholder Analysis (Appendix E) and the Sponsor Assessment (Appendix F), a Sponsor & Governance Diagram, such as Figure 15, is developed, including the sponsorship and governance approach. Referencing the Prosci® ADKAR® Model,[61] sponsorship and governance help to address the Awareness (A), Desire (D), and Reinforcement (R) for people to support the change. If additional sponsorship support is required, a Change Agent Network Diagram (Appendix H) is developed.

In addition, the **recommended considerations to help establish the project's governance** include the following (but are not limited to), which are further detailed in the Change Management Strategy (Appendix K) and referenced in the project charter, as applicable:

- understand existing governance structures and relevance to project's governance
- decision authorities and accountabilities
- roles and responsibilities
- change network
- process to resolve any issues and/or risks that require escalation
- process to request and approve any changes beyond project charter's scope

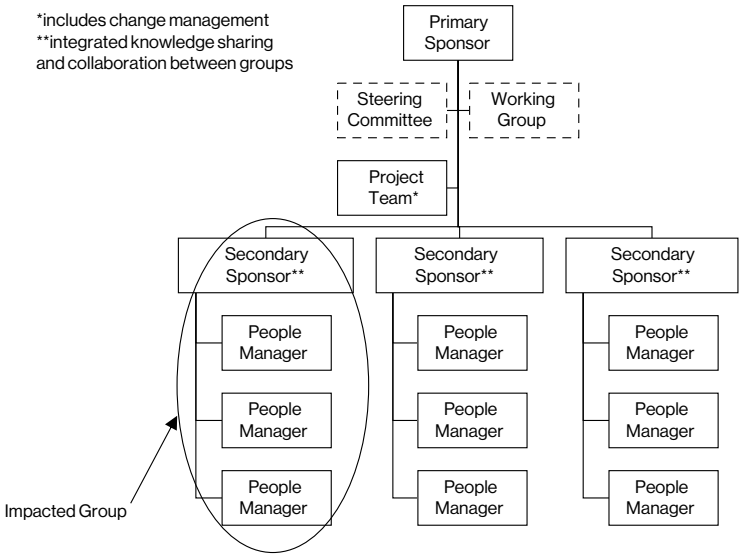


Figure 15. An example of a Sponsor & Governance Diagram

61 Hiatt, Jeffrey M. "The PROSCI ADKAR® Model." *Prosci*, 2021, https://www.prosci.com/methodology/adkar

Appendix H: Change Agent Network Diagram

Based on a hospital's unique needs, a Change Agent Network, such as Figure 16, may be developed for additional sponsorship support to implement and sustain SafER Space. The **change agent network is a group of individuals who represent various parts of the hospital, including the community it serves, which will be affected by the change.** Change agents are influencers or "change champions" who help to inspire individuals along the ADKAR® change journey. They act as a bridge between all the sponsors and stakeholders who are impacted by the change.

Instead of creating a change agent network according to an organizational hierarchy, it is recommended to organically select change agents based on key traits, such as the following:

- empathetic and a good listener
- positive influencers who naturally inspire or motivate others regardless of their title or role
- people naturally gravitate to them for leadership and/or information
- people who are seeking a leadership opportunity to further develop or showcase their talents

The Stakeholder Analysis (Appendix E) and Sponsor Assessment (Appendix F) can help to determine who is well-suited to be a change agent. In addition, the hospital's unique needs will determine how many change agents are required for each group that is impacted. It's **important to have an equitable, diverse, and inclusive network of change agents to reflect the hospital's organization and community,** which also helps to ensure a successful implementation and sustainment of SafER Space. In addition, it is important that each change agent is familiar with the change management strategy (Appendix K) and is provided with the change management tools, including communications, necessary to best help individuals navigate and adopt the change.

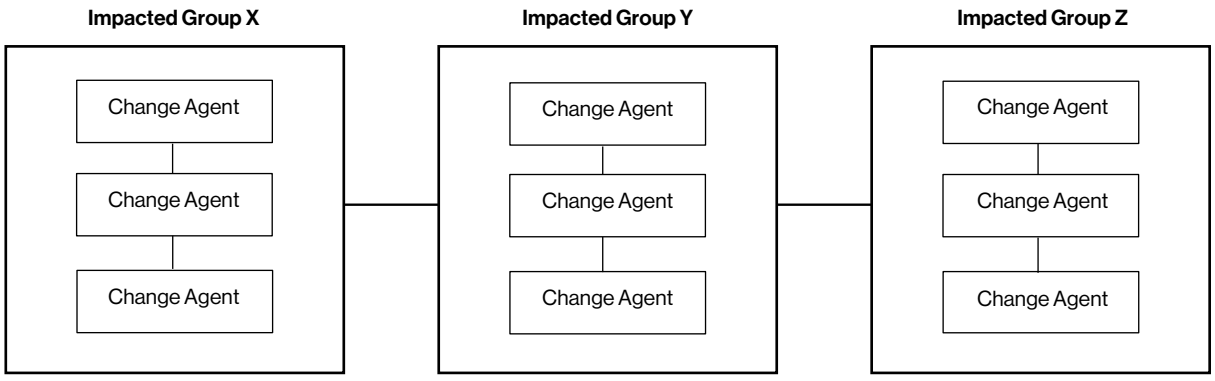


Figure 16. An example of a Change Agent Network Diagram

Appendix I: RACI Chart

The RACI Chart, such as Table 17, can be used to keep track of activities and decision-making authorities to implement and sustain SafER Space. In addition, the **RACI Chart helps to clarify roles and prevent confusion by assigning clear ownership for the project's activities and decisions.** Also, RACI Charts can help increase the project's efficiencies since it helps to guide meeting agendas and invites to include only those who need to attend.

RACI is an acronym that stands for responsible (R – person who completes the activity), **accountable (A** – has final authority or accountability for an activity's completion), **consulted (C** – an advisor for an activity), and **informed (I** – kept updated updated on an activity's completion). The first two words describe a person's role, and the last two words describe the type of communication that is required. The RACI Chart is completed by assigning the applicable R, A, C, and I for each activity; collaboration is encouraged. In addition, the following lists includes recommended best practices to complete a RACI Chart:

- assign only one accountable person per activity
- ensure the accountable assignee has suitable authority to ensure the activity is complete
- ensure there is a process in place to verify that the change is complete, considering quality, suitability, and accuracy
- make updates as needed and let people know the updates

Table 17: RACI Chart

	Project Leadership					Project Team				Change Agent Network	Impacted Group X				Impacted Group Y				Impacted Group Z			
Role	Primary Sponsor	Secondary Sponsors	People Managers	Steering Committee	Working Committee	Project Manager	Project Analyst	Change Manager	Change Analyst	Change Agents	Role	Role	Role	Role	Role	Role	Role	Role	Role	Role	Role	Role
Prepare Phase																						
Activity 1																						
Activity 2																						
TBD																						
Manage Phase																						
Activity 1																						
Activity 2																						
TBD																						
Reinforce Phase																						
Activity 1																						
Activity 2																						
TBD																						

Appendix J: Logic Model

As shown in Table 18, a **logic model can be a useful tool to "test" the relationships among inputs, activities, and outputs,** including mid-term and longer-term goals, to implement and sustain SafER Space within a hospital's emergency department. Table 18 contains items to consider when preparing to co-design SafER Space, which is then iteratively updated as the project progresses.

Table 18: Logic Model

	Funds	Emergency Departments	Community Mental Health Partnerships	Continuous Improvement	Sustainment
Inputs	*Identify what funds are allocated to cover the SafER Space Initiative, including:* • *Internal HR, IT, and facilities* • *Legal MOUs with Community Agencies* • *External consultants, such as architects, electrical, and HVAC engineers, change management consultants* • *Other?*	*Identify what is required by stakeholders impacted by the change within the hospital, and in consideration of patients and community mental health agencies, including:* • *New or revised roles, processes, procedures* • *New or revised IT systems, processes, procedures* • *New or revised training requirements*	*Identify what is required by stakeholders impacted by the change within the agency, and in consideration of patients and hospitals, including:* • *New or revised roles, processes, procedures* • *New or revised IT systems, processes, procedures* • *New or revised training requirements*	*Has an Evaluation, Measurement, and Verification (EM&V) Plan been created, identifying the following?* • *KPIs – both leading and lagging* • *Data tracking requirements to support monitoring KPIs* • *Evaluation type, method, and frequency* • *Oversight requirements to maintain objectivity of evaluation findings and improvement opportunities* • *Accountable roles to ensure findings are corrected and priority improvement opportunities are completed, including any verification process* • *Feedback loop system enables anonymous input from patients to hospital and community agencies to encourage improvement* • *Oversight governance process within hospital and between hospital and community agencies*	*Are all parties dedicated and do the appropriate roles have the appropriate RACI?* *Identify a Sustainment Plan that outlines new requirements to avoid negative quality impacts, such as the following:* • *Revised role descriptions and role interactions* • *Revised training requirements and associated refresher timelines* • *Ongoing communication protocols to share performance tracking and relevant change information within the hospital* • *Ongoing communication requirements between hospital, community agencies, and post-discharge patients*

	Funds	Emergency Departments	Community Mental Health Partnerships	Continuous Improvement	Sustainment
Activities	*What specific budget needs are required to implement and sustain the change?* *Are additional fundraising efforts required?*	*List and complete IDEA co-design change management and sustainment activities outlined in RACI Chart and the Change Management Strategy and the Project Plan.* *Is there sufficient clarity for role interactions within the hospital and with external agencies?*	*List and complete IDEA co-design change management and sustainment activities outlined in RACI Chart and the Change Management Strategy and the Project Plan* *Is there sufficient clarity for role interactions within the agency and with the hospital?*	*Complete internal processes to support the EM&V Plan, including tracking systems and monitoring programs.* *Has 3rd-party been engaged to complete the annual evaluation requirements as outlined in the EM&V Plan?*	*Has the Sustainment Plan been fully implemented?* *Have all legal requirements been fulfilled to establish partnerships between hospital and community agencies?* *Are EM&V findings being appropriately reflected in Quality Improvement Plans (QIPs)?* *Is there a target for new KPIs, including leading indicators?*
Outputs	*What line items are required to create a budget for the SafER Space?*	*List all roles, policies, and procedures in place to support SafER Space*	*List all roles, policies, and procedures in place to support SafER Space and discharge wrap-around services*	*List process for correcting evaluation findings and creation and completion of QIPs, including any new KPIs and associated definitions*	*List completed documents to support sustainment*
Mid-Term Goal	*Are additional funds required for implementation, sustainment, improvements, or additional changes?*	*Is SafER Space fully integrated into the hospital physical space, processes, procedures, and culture?*	*Is agency partnership with hospital providing full wrap-around services to discharged patients?*	*Has the EM&V Plan been implemented as scheduled and findings corrected, and have improvement opportunities been incorporated into QIPs?*	*Are the SafER Space and wrap-around systems running smoothly, appropriately resourced, and fulfilling the needs of ED and discharged patients?*
Longer-Term Goal	*Is the funding to sustain SafER Space people, process, and place included within the hospital and community agencies' operating budgets and supported by government funding?*	*Have mental health associated KPIs improved, such as workplace violence, lost-time hours, workplace insurance claims, repeat ED visits, use of physical restraints, rates of absenteeism, etc.?* *Has there been a noticeable culture shift within the hospital?*	*Have patients received supports from community agencies within the desired timeframe after hospital discharge, and to sufficiently help avoid repeat ED visits?*	*Are EM&V findings an anomaly, and are additions to QIPs informed by global emerging best practices?* *Is there a process in place to establish consistent KPIs and data tracking across other organizations to support knowledge sharing?*	*Has the SafER Space wrap-around system expanded to identify earlier intervention opportunities, thus reducing mental health related ED visits altogether?*

Appendix K: Change Management Strategy

The Change Management Strategy **includes the who, what, and how to successfully implement and sustain SafER Space,** including consolidation of findings from exercises in Phase 1 (i.e., Prepare for SafER Space):

- PESTLE[62]-SWOT[63] Analysis (Appendix B)
- Change Impact Assessment (Appendix C)
- Organizational Readiness Assessment (Appendix D)
- Stakeholder Analysis (Appendix E)
- Sponsor Assessment (Appendix F)
- Sponsor & Governance Diagram (Appendix G)
- Change Agent Network Diagram (Appendix H)
- RACI[64] Chart (Appendix I)
- Logic Model (Appendix J)

In addition, it is recommended that the change management strategy include the following:

- Background
- Objectives (i.e., actionable goals to achieve desired outcomes)
- The Role of Change Management:
  - Vision Statement
  - Guiding Principles & Values
  - Focus Areas (e.g., resistance to change)
- Change Management (CM) Approach:
  - CM Scope
  - CM Roles & Responsibilities (including how the team is prepared)
  - CM Deliverables
  - Key Stakeholders
- Success Factors, Challenges & Opportunities
- Key Performance Indicators (KPIs) to achieve the objectives
- Key Messages
- Risks to implementation and sustainment
- Based on findings from Phase 1's exercises, include applicable implementation plans (e.g., how to activate and implement the Change Agent Network)
- High-level approaches for the following (further developed in Phase 2):
  - Communications
  - Training
  - Coaching
  - Evaluation, Measurement, and Verification
  - Resistance Management
  - Sustainment

The integrated **project team, which includes change management expertise, is responsible for completing the change management strategy document,** obtaining applicable feedback before **final review and approval from the primary sponsor.** The Change Management Strategy is developed concurrently with the project plan, and it is the **final key deliverable in Phase 1,** which provides many key insights for deliverables in Phase 2 (i.e., Manage SafER Space), such as the Communications Plan.

62 Political, Economic, Social, Technological, Legal, and Environmental

63 Strengths, Weaknesses, Opportunities, and Threats

64 RACI Charts. "How-to Guide and Templates." *RACI Chart,* https://racichart.org

Appendix L: Communications Plan

While the Change Management Strategy includes a high-level approach for communications, the Communications Plan includes more detail and is developed and implemented in Phase 2 ("Manage SafER Space"). In addition, **it can be helpful to further develop the communications approach by obtaining feedback from stakeholders by means of an online survey or 1:1 interviews.** It is recommended to regularly obtain feedback from stakeholders during the project as well, to determine areas for improvement and effectiveness.

Based on findings from the strategy and feedback from stakeholders, the communications plan includes the **why, who, what, when, where, and how to communicate with the project's stakeholders,** such as the following:

- purpose (i.e., why are the communications occurring?)
- desired outcomes
- messengers and audiences of key messages
- content, timing, and frequency of key messages
- formats (e.g., PowerPoint presentation, video, infographic, designed posters, surveys, polls, events, intranet page)
- locations and delivery methods (e.g., in-person or virtual meeting, community townhall, email)

Although the specific approach will vary depending on a hospital's unique needs, it is helpful to **organize the communications deliverables** in a template, such as Table 19 with examples provided in the first row.

Table 19: Communications Plan Template

Audience	Action	Purpose	Format	Location	Delivery Method	Developed by	Delivered by	Date	Status
All employees	*Announce the SafER Space initiative launch*	*Launch the SafER Space initiative and create general awareness*	*PowerPoint presentation*	*Remote*	*Zoom*	*Name*	*Name*	*Date*	*In progress*

Within the project team, the **change manager** (or change practitioner) **typically leads the creation of the communications plan and works closely with the change agents who help to champion the change.** In collaboration with other members of the project team, they obtain applicable inputs from the Change Management Strategy and follow up with stakeholders, if necessary, before presenting a draft for the **primary sponsor's review and approval** (iteratively updating as needed). If the project has a steering committee and/or a working group, the review cycles will include their input.

When drafting the plan, it is helpful to consider how it relates to the Prosci® ADKAR®[65] [66] Model. The primary purpose of the communications plan is to address the "A" or "Awareness" and the "R" or "Reinforce" for the change. That is, for "Awareness," the plan includes the details to **clearly communicate why the change is happening and how it will impact stakeholders;** and, for Reinforcement (R), the plan includes the details to **provide results or feedback and celebrate success to sustain the change.**

65 Awareness, Desire, Knowledge, Ability, Reinforcement

66 Hiatt, Jeffrey M. "The PROSCI ADKAR® Model." *Prosci*, 2021, https://www.prosci.com/methodology/adkar

Appendix M: Key Messages

As part of the Communications Plan, the key messages are co-designed and implemented within Phase 2 ("Manage SafER Space"), which is also integrated with the project plan. **Effective communications are paramount** to the successful implementation and sustainment of SafER Space. Based on Prosci®'s **research in best practices for change management**[67], the following is recommended:

- **"Structure your efforts"**
    - intentionally communicate the right messages, at the right time, and at the right place, throughout the hospital and the community it serves
    - once stakeholders have accepted the need for change, the communications then focus more on details of the change (i.e., the SafER Space Model) and how this impacts the stakeholders (including ancillary impacts, such as processes, policies, procedures, guidelines, and technologies)
- **"Start sooner"**
    - the timing of communications is imperative for effectiveness; it is advised to start communications as early as possible, and the frequency will vary depending on the project's phase and progress
    - when stakeholders are kept well-informed with open, honest, and clear communications, they are more apt to be supportive of the change; lack of information can result in misinformation and rumours, which can impede the project's success
- **"Do it more often"**
    - communicate key messages 5-7 times for stakeholders to internalize the messages; it is recommended to cascade communications, utilizing a variety of formats and delivery methods suitable for a specific audience
- **"Answer the questions people have"**
    - it is helpful to provide sufficient opportunities and methods (e.g., dedicated webpage and email address for the project, online surveys) for stakeholders to ask questions and for answers to be provided by leaders in a timely manner; this also helps to further build trust and support for the change
- **"Use preferred senders"**
    - for communications about the change that are related to the organization, employees prefer to receive these messages from senior leaders
    - for changes that impact individuals, employees prefer to hear these communications from their manager or direct supervisor

67 Creasey, Tim. "5 Tips for Better Communication around Change." *Prosci*, https://blog.prosci.com/5-tips-for-better-communication-around-change.

Appendix N: Coaching Plan

While the Coaching Plan may be designed to facilitate understanding of the change for all stakeholders, as needed, it is **primarily designed to support people managers and how they will interact with direct reports regarding the change.** This focus is based on Prosci®'s change management research[68], which shows that people prefer to receive messages from their managers about how a change will personally affect them.

Referencing the Prosci® ADKAR® Model[69], the **coaching plan helps to address all elements of an individual's change journey to support the change:** Awareness (A), Desire (D), Knowledge (K), Ability (A), and Reinforcement (R). A **basic understanding of ADKAR® helps to identify gaps and provide suitable coaching to close the gaps.** Depending on the hospital's unique needs, the **coaching plan may include the following approach,** as recommended by Prosci®[70], for people managers to meet with impacted employees, in groups and/or individually:

- **Group Meeting**
    - describe SafER Space, including its background and context
    - introduce the ADKAR® Model and use a universal example to illustrate an individual's journey through change by applying the Model; encourage others to share an example while applying the Model
    - collaborating in small groups, employees can evaluate the organizational change required for SafER Space, in consideration of ADKAR® and identify any potential barriers or resistance to the change
    - provide opportunities for Q&A, openly discussing the change as a group
    - share next steps and how employees can obtain additional support, including 1:1 coaching sessions

- **1:1 Meeting**
    - an opportunity to further discuss an individual's change journey using the ADKAR® Model
    - acknowledge successful progress along the ADKAR® Model
    - acknowledge any barrier points to change and agree on an action plan to address this (e.g., additional training)

In addition, it may be helpful for people managers to create a matrix with each team member's ADKAR® journey and determine if there are any patterns. For example, if everyone's barrier point is the same, this can be addressed by discussing it with the entire team or otherwise addressed on an individual basis. This is an **iterative approach that helps to provide stakeholders with the information and coaching they need to effectively navigate the change journey,** helping to ensure they are successful and happy in their role that is impacted by the change.

68 Creasey, Tim. "Creating Successful Coaching with the ADKAR Model." *Prosci*, https://blog.prosci.com/creating-successful-coaching-with-the-adkar-model.

69 Hiatt, Jeffrey M. "The PROSCI ADKAR® Model." *Prosci*, 2021, https://www.prosci.com/methodology/adkar

70 Creasey, Tim. "Creating Successful Coaching with the ADKAR Model." *Prosci*, https://blog.prosci.com/creating-successful-coaching-with-the-adkar-model

Appendix O: Training Needs Assessment & Training Plan

While the Coaching Plan (Appendix N) is designed to facilitate understanding of the change related to all elements of the Prosci® ADKAR® Model[71], the **Training Plan is designed to facilitate understanding the details of how to perform the change once it has been implemented.** That is, the Training Plan addresses the Knowledge (K) and Ability (A) elements of an individual's ADKAR® change journey.

Depending on the hospital's unique needs and the communities it serves, the training needs for stakeholders will vary. Based on findings from the Stakeholder Analysis (Appendix E), **it is recommended to complete a training needs assessment, such as Table 20, which will provide further inputs for the Training Plan.** In addition, it can be helpful to further develop the training approach by obtaining feedback from stakeholders by means of an online survey or 1:1 interviews.

Table 20: Training Needs Assessment

Stakeholder or Impacted Group	Sponsor for Training	Skills or Knowledge Required After SafER Space is Implemented	Training Prerequisites (if applicable)	Training Delivery Method	Training Materials	Training Date

Before training is provided, it is important that the Desire (D) element of ADKAR® has been addressed. The **training will be less effective unless stakeholders have accepted the need for change and are wholeheartedly dedicated to supporting the change.** In general, the Coaching Plan helps to address any individual barriers along the ADKAR® change journey and, specifically, the Resistance Management Plan (Appendix P) helps to address any barriers associated with Desire (D). In addition, the Change Agent Network (Appendix H) can have a pivotal role in positively influencing individuals to adopt the change. For example, a train-the-trainer approach is a recommended practice whereby change agents are trained to train employees rather than having all-employees training facilitated by external trainers.

71 Hiatt, Jeffrey M. "The PROSCI ADKAR® Model." *Prosci*, 2021, https://www.prosci.com/methodology/adkar

When developing the Training Plan, consider including the following training items:

- objectives
- approach
- assumptions
- requirements and audiences
- roles and team members
- curriculum (e.g., Code White de-escalation practices, such as Trauma Informed De-escalation Training (TIDES), and OMEGA, as well as preventive training, such as Mental Health First Aid for Adults who Interact With Youth (soon to be renamed), ISBAR, and Patient Behavioural Screening tools)
- prerequisites
- metrics
- logistics

Within the project team, the **change manager** (or change practitioner) **typically leads the creation of the Training Plan and works closely with a training analyst and/or designer who helps to co-develop the training materials.** Inputs are obtained from the Training Needs Assessment and, in collaboration with other members of the project team and stakeholders, the **initial draft is co-designed for the primary sponsor's review and approval** (iteratively updating as needed). If the project has a steering committee and/or a working group, the review cycles will include their input.

Once training has been launched, it is recommended to **regularly obtain feedback** (e.g., online survey, 1:1 Interviews) **from trainees** during the training process to determine areas for improvement and effectiveness.

Appendix P: Evaluation, Measurement, and Verification Plan

Establishing an Evaluation, Measurement, and Verification (EM&V) Plan before implementation is critical to help ensure intended outcomes are defined. In addition, the EM&V Plan helps to ensure relevant data and information is collected and analyzed to meaningfully demonstrate SafER Space's performance in a transparent manner. It is recommended that the general framework of the hospital's SafER Space is materially consistent for at least three years to establish a new performance baseline. Incorporating improvement opportunities as much as reasonably possible is encouraged to track the transformation process and would likely not be considered material changes. It is useful to document the reporting frequency for the various activities in the EM&V Plan.

To provide a comprehensive understanding of the change outcomes, it is helpful to evaluate both quantitative performance (i.e., Impact Evaluation) and qualitative perspectives (i.e., Process Evaluation) that consider points of interest specific to SafER Space's **people, process, and place categories.** A typical EM&V Plan includes a schedule for evaluation studies and activities, identification of objectivity requirements (i.e., is a 3rd-party evaluator required for any or all activities?), any location specific details, timelines, and interconnection considerations with community agency partners. If elements of the communications and sustainment plans will be evaluated (recommended), they can also be documented in the EM&V Plan.

Impact Evaluation focuses on quantitative performance. Documenting processes and procedures used to collect the desired data, as well as definitions of the data, and the data collection frequency is helpful to include in the EM&V Plan . Data considerations include the following:

- count of people seeking and receiving mental health supports and count of those who left
- time elapsed between arrival, peer support contact, and ED triage
- time elapsed between ED triage and psychiatry or psychology consult (i.e., duration of stay, including any admission time)
- time elapsed between discharge and continuity of care (i.e., confirmation of continuity of care; and, date, time, and frequency of patient follow-up if no continuity care service accessed)

Process Evaluation provides insights into how the change is perceived from direct experience and is typically not conducted until one year after the change is implemented. Process evaluations help to identify quality improvements for SafER Space's people, process, and place categories through a formalized and objective feedback loop to support a learning organization that adapts to reflect the experiences of its users, including employees and patients. The Logic Model (Appendix J) and PESTLE[72]-SWOT[73] Analysis (Appendix B) are useful tools to help define the process evaluation parameters. As noted with the Impact Evaluation,

72 Political, Economic, Social, Technological, Legal, and Environmental

73 Strengths, Weaknesses, Opportunities, and Threats

the Process Evaluation typically identifies how the information will be collected, with what frequency, and how it will be reported, along with the qualitative parameters (usually in the form of questions).

For example, a an EM&V Plan may identify the need for an annual process evaluation study that includes in-depth interviews with ED employees in addition to monthly rapid response email or telephone surveys fielded to a random sample of different patient segments after discharge, and explore insights, such as:

- if ED services were not accessed, what was the reason (if any)?
    - was a follow-up plan created?
    - how long after person left ED was the follow-up plan implemented?
    - what was the outcome?

- what was the experience with peer support like?
- was the consult with psychiatry or psychology timely? Was it helpful?
- how did the hospital admission process go?
- how did the post-discharge continuity go?
- what was the perception of the patient and their families?
    - Were their needs met?
    - Were there things that could have been done better?
    - Were there things that went really well?

The reporting requirements for the evaluation studies and activities are also included in the EM&V Plan, as is the role accountable for the EM&V Plan. In addition, it is recommended that a role is allocated (e.g., change practitioner) to integrate performance measurement of new indicators associated with SafER Space and managed by the performance operating system and the ED.

Appendix Q: Resistance Management Plan

Referencing the Prosci® ADKAR® Model[74], the "D" or "Desire" for people to support the change is typically the most difficult to achieve. For a successful implementation and sustainment of an organizational change, it is vital to having stakeholders who wholeheartedly support the change. In general, the Coaching Plan (Appendix N) helps to address any individual barriers along the ADKAR® journey and, specifically, the **Resistance Management Plan helps to address any barriers associated with the Desire (D) to support the change.** In addition, the Change Agent Network (Appendix H) can have a pivotal role in positively influencing individuals to adopt the change.

Although change is constant, it is also constant for many people to resist change, in varying degrees, whether it is viewed as "positive" or "negative." That is, resistance it is a natural and inevitable reaction to change. The degree of resistance to change, and its effects, depends on the individual and the situation. For example, people may resist change because they are not given an opportunity to become involved in decisions related to the change that affects them. This is one of the many reasons why one of SafER Space's principles is to **co-design with those who have direct experience with child and youth mental health,** including youth, caregivers/families, peer workers, mental health clinicians, and professionals within the ED.

To effectively manage resistance, instead of trying to transform all resistance to support, it is recommended to **identify the "primary resistors" (i.e., those who have the most negative influence) and develop strategies to positively influence them to support the change.** If possible, it is ideal to collaborate with the "primary resistors" to develop the strategies that will address their needs to support the change.

The following are **examples of why people may resist a change:**

- do not feel they have an opportunity to provide feedback
- feel they lack choices or options
- do not have a clear understanding of what the change is and why it is happening
- believe they may lose something of value (e.g., renumeration, status, job)
- lack of support from management and/or leadership
- past experience with implementations that were unsuccessful
- are overwhelmed with change
- concern they won't be able to develop the skills and/or behaviours required for the change

The following are **approaches for navigating resistance to change:**

- wherever possible, collaborate with stakeholders to co-design the change
- regularly communicate clearly, openly, and honestly about the change
- regularly provide opportunities for stakeholders to provide feedback (e.g., online survey, dedicated email address, meetings); empathetically listen and be open to feedback; respond to feedback in a timely manner; and, whenever practically possible, integrate

74 Hiatt, Jeffrey M. "The PROSCI ADKAR® Model." *Prosci*, 2021, https://www.prosci.com/methodology/adkar

feedback for continuous improvement

- encourage open/healthy discussions about resistance, including encouragement of ideas to address resistance
- provide evidence that the change is needed
- demonstrate the benefits of the change
- provide recognition awards, incentives, and/or rewards for adopting the change
- provide sufficient time for people to absorb information and adjust to the change
- implement a Coaching Plan to help guide stakeholders through the ADKAR® journey; wherever possible, collaboratively remove barriers
- implement a Change Agent Network, empowering change agents to positively influence individuals to support the change
- implement a Sustainment Plan (Appendix R), reinforcing the change and ongoing support for stakeholders along the ADKAR® journey

Appendix R: Sustainment Plan

Once a change is implemented, it is important to provide sufficient time and support for stakeholders to adjust to the change. Referencing the Prosci® ADKAR® Model,[75] the **Sustainment Plan helps to address the Reinforcement (R) element for people to continue supporting the change.** Prosci® defines Reinforcement (R) as an action or an event that supports organizational change or increases the likelihood that it will sustain. Prosci®'s research shows that "[w]hile making a change is difficult, sustaining a change can be even more difficult. This is why reinforcement is such a critical element of successful change."[76]

As outlined in the Change Management Strategy (Appendix K) and further detailed in the Evaluation, Measurement, and Verification (EM&V) Plan (Appendix P), it is critical to obtain quantitative and qualitative data to analyze metrics, including KPIs, for the purpose of identifying areas of improvement and effectiveness throughout the project. Particularly for Phase 3 (i.e., Reinforce SafER Space), this **evaluation helps to discern if the change was successfully implemented and, if not, to otherwise adjust.** Once a hospital implements SafER Space, it is recommended that the framework is materially consistent for at least three years to establish a new performance baseline.

Depending on the hospital's unique needs, the Sustainment Plan may include updated versions of change management plans from Phase 2, such as the Communications Plan (Appendix L) and the Resistance Management Plan (Appendix Q). In addition, to help prepare for sustainment, Table 21 is an example of a checklist that may be helpful. Also, it is recommended that sustainment actions are identified and tracked in a RACI Chart (Appendix I) format or similar.

Table 21: Sustainment Checklist

Deliverables	Yes	No
Have required activities been identified to transition the project to operational status?		
Is there an established process for monitoring, tracking, and evaluating progress?		
Is documentation (e.g., policies, procedures) developed and/or updated to sustain the implementation?		
Are sufficient funds and resources allocated to sustain the implementation?		
Have escalation processes been identified?		
Is there a process established to capture feedback on a regular basis?		
Is there a process established for identifying and celebrating successes?		
Is there an established process for ongoing communications with stakeholders?		
Are applicable processes and technologies aligned?		
Has the project conducted a Lessons Learned Session(s) to capture, share, and learn about areas of improvement and effectiveness?		
Is the project close-out report completed? Has it been reviewed and approved by the primary sponsor?		

75 Hiatt, Jeffrey M. "The PROSCI ADKAR® Model." *Prosci*, 2021, https://www.prosci.com/methodology/adkar

76 Hiatt, Jefferey M. "Reinforcement - the Prosci® ADKAR Model." *Prosci*, https://www.prosci.com/resources/articles


EMERGENCY

Myles Ahead, Advancing Child & Youth Mental Health, is a national charity that approaches initiative development and program implementation through a holistic or full-systems lens, including inclusion, decolonization, diversity, equity, accessibility, and anti-violence. The emphasis of Myles Ahead's work is to improve the first point of access to mental health services and crisis supports in health care, communities, and school settings.

MYLES AHEAD
ADVANCING CHILD & YOUTH MENTAL HEALTH

www.mylesahead.ca
53 Kerr Road, Toronto, Ontario, M4L 1K2
Registered Charity #72688 1717 R0001